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THE PROPOSED FISCAL YEAR 1988 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MARCH 13, 1987

Serial No. 100-3

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PROPOSED FISCAL YEAR 1988 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS

FRIDAY, MARCH 13, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room 628, Dirksen Senate Office Building, Hon. John Melcher (chairman of the committee) presiding.

Present: Senators Melcher, Chiles, Shelby, Reid, Heinz, Grassley, Domenici, Chafee, and Durenberger.

Also present: Max I. Richtman, staff director; Christine Drayton, chief clerk; Stephen R. McConnell, minority staff director; Chris C. Jennings, professional staff; Bill Benson, professional staff; Dianna Porter, professional staff; Annabelle Richards, professional staff; Laura Erbs, minority professional staff; Holly Bode, legislative correspondent; Craig Obey, legislative correspondent; Jennifer Bonney, legislative correspondent; and Dan Tuite, staff printer.

OPENING STATEMENT OF HON. JOHN MELCHER, A U.S. SENATOR FROM THE STATE OF MONTANA AND CHAIRMAN, SPECIAL COMMITTEE ON AGING

The CHAIRMAN. The committee will come to order.

This morning we're going to delve into the Administration's budget, President Reagan's budget, and look at those aspects of the President's budget that deal with the elderly. I've already done that, but we want to hear it from the Administration's witnesses.

Now, I do not expect the witnesses for the Administration to do anything but attempt—and I really say "attempt" in quotes—to justify some outrageous suggestions.

Item: Medicare would be cut $5.1 billion.

Item: The Low Income Energy Assistance Program would be cut.

Item: Housing construction for the elderly would be severely curtailed. We'd just about abandon it.

Item: The Older Americans Act could be subject to, at this point, unknown cuts.

Now, I think it's right that if you're on a team, the President's team, and you're a part of the Administration, you have to come up and say why this type of action is justified. But I don't expect anybody else to justify it. I don't anticipate that either side of this committee is going to say that's what we want to do.

So first off, I want to assure the elderly who might be paying attention to this hearing that we would not anticipate under any circumstances that the programs, and budget cuts that have been recommended in the President's budget that I have mentioned, will become law. That is because neither the people of this country nor the Congress, representing the people of this country, believe that this is a type of priority that we want to establish, that this would be the type of fairness—or, rather, unfairness—that we would want to commit upon the older Americans in this country.

But we'll listen and we'll question the thinking behind these outrageous proposals, and then we'll go on from there and see whether we can devise a better budget in Congress.

Senator Heinz.

[The prepared statement of Senator Melcher follows:]

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WASHINGTON, DC 20510-6400

OPENING STATEMENT

SENATOR JOHN MELCHER
Chairman, Senate Special Committee on Aging

March 13, 1987 hearing
The Proposed Budget For Fiscal 1988:
What It Means For Older Americans

Good morning. On behalf of my colleagues, I'd like to welcome everyone to today's hearing by the Senate Special Committee on Aging.

This morning, we want to take a closer look at President Reagan's proposed budget for fiscal year 1988 -- and what it means to this country's senior citizens.

The administration's budget proposal, even in its current infant state, already has earned a niche in the record books. For the first time in history, the administration is proposing to spend more than $1 trillion for the multitude of federal services that keep this country operating.

It is a budget that will require the spending of more than $100 billion that isn't there -- deficit spending.

It is a budget that includes increases in spending for such things as defense and foreign aid.

And it is a budget that includes reductions in spending for many domestic programs, such as medicare and medicaid.

Just what those and other reductions will mean to the quality of life for a large segment of this country's population is the focus of today's hearing.

Those questions also are the focus of a detailed analysis of the President's budget prepared by the majority staff of the Senate Special Committee on Aging. That analysis is being released today and is available to the public at the back of the room.

Quite frankly, I've got more than a few concerns about who will wind up footing the bill for the fancy, new weapons systems the President wants. The defense contractors certainly won't build those weapons for free.

No, I fear the bulk of the bill for that hardware will be sent directly to those who can least afford to pay for it -- America's elderly and other low-income citizens. It won't be as blatant as asking them to go down to their local defense contractor and write out a blank check. It will be more subtle and cruel. The elderly will pay through significant reductions in the quality of their lives, through cuts in Medicare or Medicaid, low-income housing, assistance with heating bills and research into medical problems like Alzheimer's Disease.

It shouldn't come as a surprise. This administration has a track record of trying to back out of its commitments on important social programs.

For example, in the last six years, the deductible for hospitalization under Medicare has been increased by more than 150 percent. In addition, during those same six years, the premium for physician and other costs under Part B of Medicare has been increased by more than 85 percent. And the list goes on.

This isn't just rhetoric. There are millions of senior Americans who worry that the social programs they had counted on for their retirement years, programs like Medicare, will be greatly diluted by the time they retire.

These are real and legitimate fears from the part of America that depends on those programs the most. I've heard those fears repeated time and again by seniors not just from my home state of Montana, but from all over the country. And I'm sure my colleagues have, as well.

I find it ironic that at the time the administration is proposing a much-needed plan to protect Americans against the cost of catastrophic illnesses, it also wants to increase out-of-pocket costs for older Americans through significant cuts in the budget.

Today, we'll be looking to our distinguished witnesses for some answers to some tough questions.

We want to know how the Administration can cut more than $6 billion from the Medicare program, yet assure beneficiaries they won't have to choose between paying for their groceries and paying for necessary medical care.

We want to know how proposed cuts in important biomedical research will affect our efforts to find the cause, treatment and cures for such devastating conditions as Alzheimer's Disease and osteoporosis.

We want to know why the administration is grouping 26 separate social services programs, including the Older Americans Act and programs for children, the developmentally disabled and Native Americans under one catch-all, or generic, funding category. We want to know how much money will be going to each program and who is going to make that decision. And we want to know why the administration thinks it can do a better job of setting priorities than Congress.

We also want to know how the administration can eliminate 4,000 staff positions in social security field offices next year and a total of 17,000 over five years and still maintain quality service.

These are only a few of the questions we've got on our minds this morning. And by the end of today's hearing, I'm hopeful we'll have some answers. I hope we'll have a far clearer picture of exactly how the President's proposed budget would affect America's elderly this year and in the years to come.

Frankly, I'm disappointed in what the President has proposed, particularly in the way he comes back to us each year with many of the same proposals that failed the year before. Fortunately, for America's elderly and poor, I believe the Congress will again reject much of the President's budget. This hearing will go a long way to point out the potential harm of the Administration's plan and lead to acceptable and compassionate alternatives.

Today, we'll be hearing from the administrator of the Health Care Financing Administration, William Roper. His agency administers the Medicare and Medicaid programs for more than 30 million elderly beneficiaries.

We also will hear from James Wyngaarden, who is the director of the National Institutes of Health. He is accompanied by T. Franklin Williams, director of the National Institute of Aging, which does research into social and medical issues facing the nation's aged.

Representing the Office of Human Development Services will be Carolyn Gray, acting deputy assistant secretary. She will be accompanied by Carole Fraser Fisk, commissioner of the Administration on Aging.

In addition, the Social Security Administration will be represented by Nelson Sabatini, deputy commissioner of management assessments.

Because of time constraints, we've limited the number of administration witnesses to four. Clearly, there are many other areas of the President's budget that these four witnesses won't be able to address, such as programs administered by the Department of Housing and Urban Development. That doesn't indicate this committee isn't interested in those issues. We are concerned about those areas and others, but we simply don't have time to explore them today.

Representing senior citizen groups will be Eugene Lehrmann of the American Association of Retired Persons and Jake Clayman, president of the National Council of Senior Citizens. I'd also like to commend the many organizations that have submitted statements for the record, expressing their concerns about the President's proposed budget.

I'm looking forward to the information our witnesses will present today. And when we're done, I'm confident we'll all have a much clearer picture of the outlook for seniors under the President's budget.

STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE COMMONWEALTH OF PENNSYLVANIA

Senator HEINZ. Mr. Chairman, first let me congratulate you on calling this hearing today. I think that it is important that this committee examine the President's budget proposals for the fiscal year; indeed, we have made a practice of it in the past.

In connection with the fiscal year 1988 budget, I think it's fair to say that some people have said that this budget is dead on arrival. I don't think the issue is whether this budget has arrived belly-up or armed for battle; a budget will emerge from the House and the Senate that is going to be eventually agreed upon with the Administration. We all know that economies and cuts are going to be a part of that budget if we're going to get the deficit down.

So at issue, as we put this particular part of the budget under the committee's microscope and dissect it, is whether the budget mirrors or mutates our historic commitment to a secure, healthy old age for all Americans. And I stress here our commitment to achieve these goals, and would also underscore the critical importance of that commitment as an ongoing effort by this committee.

It is true that in the past two decades, particularly since the creation of Medicare, we've witnessed great strides in the financial and physical well-being of the elderly in this country. But the miracles of Medicare and the securities of our social programs weren't pulled out of some magician's hat. They were built with the hard-earned dollars of the American taxpayer and, I'd like to think—since I've been here a few of those years—a little wisdom in Congress in investing those dollars in programs that will benefit us all.

I think that to take pride in our successes is justified, but, frankly, not as an excuse to fall back in our efforts. I don't think that we should turn our back on 20 years of commitment by nickel and diming our achievements to death. Let's take one example, Medicare.

Today, older Americans spend, on average, 15 percent of their incomes on health care. That may or may not sound like much to many people, but the reason we enacted Medicare in 1964 is that the elderly then were spending 15 percent of their income on health care. Medicare was the invention of the political process to address what then was thought to be an extremely serious problem; and at least statistically, if we use percent of income as a measure, we are today where we were 20 years before. The deductible for a hospital stay today is $520; that is literally a hardship for many seniors on fixed incomes. And taking an additional $5 billion out of the Medicare budget, as is proposed, poses a potentially difficult, even somewhat deadly, blow for millions of our oldest and poorest and most vulnerable citizens.

Now, I recognize that spending cuts are argued in the name of economy, and I also recognize and subscribe to the proposition that our current deficits—$170 billion this fiscal year—are untenable. But I would argue that there are economies to be made that can reduce the need for cuts, and we should work with the former rather than the latter whenever possible. To use the Medicare Program as one example, there are two efficiencies that have recently been enacted. Dave Durenberger, who is here, is quite familiar with that, as is John Chafee; we are all on the Finance Committee where we did these things. The first is the pacemaker registry; the second is the second surgical opinion program. Both would save lives and enhance the quality of life for seniors. Neither has yet been fully implemented.

The Federal Government also loses millions of dollars a year because it fails to collect on warranties from failed pacemakers, and I can think of literally dozens of other examples where we can get savings without in any way reducing our commitment to senior citizens. Indeed, we may be able to improve it.

Investing in health care research is yet another way we can reduce the future cost of caring for the elderly. I would note that diverting funds away from Alzheimer's disease research not only guarantees a future of higher Medicaid expenditures for nursing home care, but it leaves millions of victims and their loved ones in financial and emotional despair.

Mr. Chairman, I'm releasing today a report on the effects of the President's budget which has been prepared by the minority staff. It's not terribly lengthy—it's about 16 pages, single-spaced for the most part—but I think it will prove a valuable analytical tool for both the majority and the minority, and I would ask that it be a part of the record.[1]

The CHAIRMAN. It will be a part of the record immediately following the printing of the analysis of the majority staff,[2] which is 40 pages and also single-spaced and is also——

Senator HEINZ. Mr. Chairman, I am tempted to strongly object to the fact that the majority is getting 40 pages and the minority only 16. The ratio in the Senate is not nearly that big between the majority and the minority, but I commend nonetheless the Chairman and the majority for doing a comprehensive job.

The CHAIRMAN. I think hereafter we'll combine, if the minority is willing, the efforts of the majority staff and the minority staff on budget analysis. I don't think we're going to come out with any degree of differences on our votes on how we vote on questions affecting the older Americans, and I don't know why our staffs shouldn't be coalesced together on these.

Senator HEINZ. Mr. Chairman, I'm sure there is a way we can avoid duplication and work together on that. Certainly, we would welcome the opportunity to be a part of any such process.

The CHAIRMAN. These are available, I might say—both of them are available from the committee, and we welcome anybody's examination of them because I think that as we go through this whole process this year, our best ammunition on the Senate floor representing the elderly of this country is going to be a well-informed body of Americans that are interested in these programs.

Senator Durenberger.

STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator DURENBERGER. Thank you, Mr. Chairman. I will be brief.

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[1] See appendix, p. 285.

[2] See appendix, p. 249.

I want to congratulate you for holding this meeting. I want to say, though, that as you know, it is in the tradition of John Heinz who really began this in his chairmanship of this committee to put our accent where many of our elderly put theirs, on the issue of health. So I think it's appropriate, in the future, that if we're going to have one report, it's OK the first time if we have one from John—the minority side—and one from your side——

Senator HEINZ. That's just transition.

Senator DURENBERGER [continuing]. Because it's appropriate to the tradition of this committee.

I'd like to make two observations. I just had a chance to look at our colleague, Pete Domenici's, statement. He, like all of us, says, "We need to be reminded often of our special responsibility to assure the elderly of adequate income, decent health care, and peace of mind, that the benefits will continue." And we assure ourselves, those of us who are in mid-life, assure ourselves of our obligation to the older generation all the time as we do to the younger, and that's just part of generational equity in America. That's the way it has always been, that traditionally we were helped by someone somewhere along the line; we then exchange that, as far as our children and our parents are concerned. I think it's appropriate to say that because in the context of this hearing in particular, I'm going to ask Bill Roper and others questions like, why the savings that they suggest.

As far as I'm concerned, if we save $4.7 billion out of elderly accounts, we're not going to spend that on children or we're not going to spend it somewhere else. If we haven't made a commitment to take care of children so far we aren't going to make it just because we're saving something from the elderly.

So one of my concerns here, as I look at the Administration's budget, is, what's the purpose of the recommended savings?

I don't think, Mr. Chairman, that we can quantify this issue of appropriations or spending for the elderly either; and again, I'm not saying this critically of my colleague from New Mexico because he's just bringing us facts. But we see this all the time; here are $63 billion spent on the elderly in 1965, which has increased to $259 billion in 1985, all measured in constant 1985 dollars. The presumption there might be, well, we're doing just fine by the elderly because we're spending four times as much money today as we did at some other time. I don't think that's the point, either, and knowing Mr. Roper and the others here I think that they would probably agree with that. It isn't how much you spend; it's how you commit these resources, how you commit your public as well as your private resources.

So I'll be asking questions about what we are doing to simplify the access to health care in this country, what we are doing about private health plan options, how we are moving in the direction of making the elderly or helping the elderly in America to be smarter buyers, not confusing them with a lot of paperwork and three or four or five or six different plans that they have to buy in order to get protection that they aren't even sure that they have.

So I would say, Mr. Chairman, that yes, we are the Nation committing resources from our generation to the elderly, but how we commit those resources is much more important than the volume of those resources, and I'm sure that those for whom we have responsibility here on this committee would recognize that as our first responsibility as well.

The CHAIRMAN. Senator Shelby.

STATEMENT OF HON. RICHARD SHELBY, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator SHELBY. Thank you, Mr. Chairman.

Mr. Chairman, I'd like to begin today by commending you and the committee staff on organizing this hearing this morning. As a new member of the Aging Committee, I'm greatly concerned with the plight of many of our Nation's elderly. While fiscal responsibility is surely a priority, we can't attempt to balance the budget at the expense of our senior citizens.

Our task today is not a simple one. We've invited these distinguished individuals here to help us begin to consider some of the President's fiscal year 1988 budget. More specifically, we need to evaluate how the President's budget proposals are going to affect our Nation's elderly from health, housing, income, Social Security and other standpoints. Our assessment will, I believe, in turn help us determine what action is needed to insure that older Americans are receiving to the fullest degree the rights and the benefits they unquestionably deserve and have earned.

Protecting our Nation's elderly, their rights and benefits, is one of our top priorities for this historic 100th Congress; but to succeed, to respond with compassion and yet foresight to the needs of today's elderly, as well as the seniors of tomorrow, you and me, is a task which will take strong bipartisan effort.

I'd like to thank our distinguished witnesses for taking the time out of their busy schedules to be with us this morning, and I especially want to commend Dr. Roper, a fellow Alabamian, for being here with us.

The CHAIRMAN. Senator Chafee.

STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. I also am delighted that you are holding these hearings and that the precedent was set by Senator Heinz when he was chairman of this committee, likewise.

I think my experience with the elderly is similar to that of others, namely, the greatest single concern of the elderly is for the potential medical bills that they might run up. In other words, medical expenses are the greatest concern of the elderly, certainly in my State, and I suspect that's true nationally. So therefore, any suggestion that there be these deep cuts in Medicare and a cap on Medicaid has me very concerned, and something that I am not interested in seeing done.

I'd like to just briefly touch on the proposed cap on the Medicaid Program. Mr. Chairman, this is a track we've been around before. We met with this in the Finance Committee, and twice I happened to be in the van on this particular measure of resisting it, and twice we were able to defeat such changes. I think it's very important to remember that the long-term care services for the elderly alone account for almost half of the costs of the Medicaid Program. Half of all elderly nursing home residents are newly impoverished, and a cap on the Medicaid Program would put enormous pressures on the States to limit their benefits packages to emergency services or to basic hospital/nursing home physician care.

The development of home health care, for example, or preventive health care services would be stopped in its tracks under any proposal like this for the cap on the Medicaid. I'm just opposed to that, and I am particularly interested in pursuing efforts along the lines of preventive medicine; in other words, doing everything you can to keep this population—and any population, but here we're dealing with the elderly—keeping them healthy. And that's the best thing we can do, it seems to me, because obviously we're having greater longevity. This group is living longer, but we don't want people just living longer; we want them to live longer and to live healthy lives, and that can be accomplished under the preventive measures and that will not be accomplished under the cuts that are proposed.

So, Mr. Chairman, again I am glad that we're here today.

The CHAIRMAN. Thank you very much, Senator Chafee.

Our first witness, of course—oh, excuse me, Senator Reid. How could I forget you?

Senator Reid.

STATEMENT OF HON. HARRY REID, A U.S. SENATOR FROM THE STATE OF NEVADA

Senator REID. Thank you very much, Mr. Chairman.

I'd like to compliment you for holding this series of hearings. I had experience on the House Aging Committee, working with Senator Pepper and Chairman Roybal. I've been very impressed by the way that you've handled this committee and the hearings that have been arranged for us to attend. This budget hearing is certainly no exception to that, and I appreciate—as my colleague from Alabama indicated—the people coming here on this day to appear before us.

There are a number of things about which this committee is concerned, including catastrophic health care. A number of bills have now been introduced, and we are facing a real challenge to determine what is the best method to correct this all-too-apparent problem that we have called catastrophic illness.

Another concern that I have that I hope will be touched upon today is the fact that the Social Security Administration has budgeted staffing reductions during the next few years of some 17,000 people. We have to make sure that the Social Security Administration can still meet the needs of the beneficiaries of this country. In Nevada, as an example, there are proposals to close the contact stations that field representatives use when they travel to work with beneficiaries in many of the outlying areas in Nevada, and it's a concern of mine that the Social Security Administration will be able to meet the demands of the people in rural Nevada and rural America.

I am very interested in finding out what alternatives are available to Social Security beneficiaries in these rural areas who are no longer able to work with field representatives as a result of the budgeted staffing reductions that I've talked about.

Again, I commend you and the staff for the hearings that have been arranged and look forward to the testimony here today.

The **Chairman**. Thank you, Senator Reid.

Senator Grassley.

STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM THE STATE OF IOWA

Senator **Grassley**. Mr. Chairman, I appreciate the opportunity to review with the committee the Administration's budget proposals as they would affect older people. It's true that we've heard a good deal already about the budget, in the Budget Committee in the Appropriations Committee, and in this committee. However, this hearing, I think, provides us a very good opportunity to look relatively systematically at how the budget proposals of the Administration are going to affect older people.

We are scheduled to start marking up a budget resolution in the Budget Committee next week. I think it's safe to say that we will be no more disposed this year than we were in the last one to accept many of the budget proposals contained in this budget. Last year we were able to get about $20 billion out of the Defense budget and thereby preserve more adequate funding levels for some of our most important domestic programs. If we stick with the Gramm-Rudman-Hollings targets, we will need at least $8 billion to $10 billion from the Defense budget if we're going to keep funding levels for these domestic programs at adequate levels.

However we decide to proceed—and there is still a lot of debate about that—I feel confident that we will have trouble accepting many of the specific proposals made by the Administration. One example which is of concern to me and which I feel sure will be of concern to other members of the committee is a proposal for a generic budget for about 26 social service discretionary programs administered by the Office of Human Development Services. This seems like a strange proposal on the face of it, and I'll be interested in hearing how the Administration thinks it would work if implemented.

And so, Mr. Chairman, I look forward to the analysis of this problem that we're dealing with by the witnesses today, but I also know that when our budget is finally adopted this summer or fall, that the programs for older Americans are not going to be adversely affected as they would with the proposal that comes from the White House.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Grassley.

Dr. Roper, you're our first witness this morning. We will listen while you present whatever advice you can give us on why the President would choose to cut $5.1 billion out of Medicare and cap Medicaid at $26.9 billion. That is, I take it, passing on a larger chunk of Medicaid payments to the States and to the counties.

I must say that I'd like you to summarize your comments, Doctor. I'm sure there will be some questions, and if you could summarize your statement in 10 minutes, that would allow us some time for some questions.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. Roper. Thank you, Mr. Chairman, members of the committee. I am delighted to be with you and would like to submit my written statement and summarize it if I could.

I am delighted to be here to discuss the President's Medicare and Medicaid proposals for next year which affect the elderly. And if I also can add a personal note, I'm pleased to get a chance to visit with my good friend, Senator Shelby. He and I have known each other for a number of years; we're from little towns just a couple of miles apart near Birmingham.

We share the same goal of assuring high quality health care services for the Nation's elderly through Medicare and Medicaid. Our 1988 budget of over $100 billion proposes a net increase in program spending while limiting the rate of unnecessary growth. Only 4 percent of our proposed reductions to the projected rate of increase affect beneficiaries.

Our proposals are designed to meet several goals. First, to assure high quality in the health care services we purchase through Medicare and Medicaid. Second, to expand and extend competition and choice for both beneficiaries and consumers as a mechanism for maintaining quality and controlling growth of expenditures. And third, to improve how we manage this agency, the Health Care Financing Administration, so that we can be a fair business partner with all concerned with health care, and most importantly, with the beneficiaries.

Let me highlight for a moment the President's proposal to provide improved catastrophic illness protection in the Medicare Program. You are, of course, familiar with that proposal. It's the first major new protection in basic benefits since Medicare was introduced two decades ago. Only a small number of elderly are protected from the financial disaster of acute catastrophic illness; but under the President's and Dr. Bowen's plan, for an additional small premium each month, beneficiaries would be covered for out-of-pocket costs for covered services that exceed $2,000.

I'd also like to discuss one of our highest priorities, one that Secretary Bowen and I share, and that is assuring quality in our health care services. Our budget for Medicare and Medicaid makes a strong commitment to monitoring quality and taking appropriate action when problems are found. Among the things we are now doing, is a new PRO scope of work which emphasizes quality of care review, including denying payment for substandard care. In addition, we are implementing a new quality review process for beneficiaries who are enrolled in health maintenance organizations and competitive medical plans. We are requesting new legislation to strengthen our ability to penalize plans that do not perform up to required standards.

We are requesting increased funding to review the health and safety of persons in institutions. This review is emphasizing outcomes of care, and includes many of the recommendations from the

Institute of Medicine study for improving the quality of care in nursing homes.

We are committing $7 million of our research budget, about 20 percent of the money, to improving our knowledge in the area of quality.

This year, as you know, we're proposing a major initiative to give beneficiaries and providers broader opportunities to participate in Medicare and Medicaid through private health plans. We believe that managed care, coupled with per capita payments, gives incentives for providers and physicians to look at the entire range of a patient's health care needs and to assure that care is delivered in the appropriate setting.

Alternative plans, such as HMO's and competitive medical plans, are attractive to beneficiaries because they usually provide more benefits than traditional Medicare. Our proposals concerning Medicare deal with private health plan options giving expanded choice, for example, employer-based options. In addition, we propose increased incentives for HMO's and competitive medical plans to participate in the Medicare Program, and expanded research and demonstrations to answer the many important questions that this whole activity raises.

For Medicaid, we propose to spur the growth of new managed care systems by selectively increasing the Federal match rate to the States for a 3-year period.

Our budget includes a number of proposals that will promote increased competition and efficiency among health care providers.

The budget proposals include several ideas to address excessive variations in Medicare's charge-based payment system for physicians. In addition, we propose to establish a more reasonable payment rate for cataract surgery, and to reduce unnecessary payments for radiology, anesthesiology, and pathology services to hospital inpatients.

The net effect of these physician payment reforms is to reduce the estimated beneficiary premium costs, a savings to beneficiaries.

We also propose to extend the recently enacted standards for prompt payment of a 30-day ceiling for clean claims to 1988 and beyond. In addition, we would establish a 28-day floor under such payments. We believe that a 30-day claims payment cycle is a policy that is reasonable; but more importantly, our proposal results in budget savings that help us avoid more onerous cuts with little financial impact on beneficiaries.

In addition, our budget includes several proposals that will modestly increase Medicare beneficiary financial participation in the program. We understand and share your reluctance to impose any hardship on our most vulnerable elderly, but we believe that the additional costs that will result from our proposals are minimal and that modest cost-sharing is a legitimate means of assuring appropriate utilization of services. These changes include a restructuring of the Medicare Part B premium, indexing of the Part B deductible, requiring a full month after age 65 before Medicare eligibility begins, and enrolling certain State and local employees in the Medicare Program.

As I mentioned earlier, we're also moving to improve the management and efficiency of Medicare and Medicaid, especially our beneficiary services. We propose to control the growth of the Medicaid Program, which continues to rise at three times the rate of general inflation, by imposing a limit on the payments to the States coupled with improved flexibility so that States can restructure their medical assistance programs.

We are also improving services to beneficiaries, such as faster toll-free telephone service and a new system to review appeals of hospital discharge decisions.

In conclusion, let me say that our 1988 proposals provide the elderly with important financial protections and assurance that there will be access to quality health services. Our catastrophic proposal provides beneficiaries with financial protection for out-of-pocket costs; our private health plan option offers increased choice and opportunity; and our investment in quality means that changed financial incentives will not result in a lower standard of care.

I'd be pleased to answer your questions. Thank you.

[The prepared statement of Dr. Roper follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT Of

WILLIAM L. ROPER, M.D.

ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

MARCH 13, 1987

I appreciate the opportunity to appear before you today to discuss the Administration's FY 1988 Medicare and Medicaid proposals which affect the elderly.

The Medicare and Medicaid budget supports high quality and accessible health services for the elderly. We are proposing a net increase in program spending for covered services, while limiting the rate of unnecessary growth. We also propose major new initiatives that will provide beneficiaries with an expanded range of health delivery choices as well as financial protections not currently available.

Before I describe our specific proposals for FY 1988, I would like to highlight several of the overall goals that our proposals are designed to address.

First, this Administration is committed to maintaining and enhancing a high level of quality throughout the Medicare and Medicaid programs. Our proposed resource allocations and our rigorous efforts to improve detection of quality problems demonstrate this.

Second, it is our belief that maintaining quality and controlling the growth of health care costs can be accomplished through the expansion and extension of competition and choice for both beneficiaries and providers. Our private health plan option for Medicare beneficiaries and other reforms represent our commitment to this important effort.

Third, I want the Health Care Financing Administration to be a fair business partner that works better for the benefit of all concerned with health care. This commitment includes our interest in improving management of the Medicare and Medicaid programs and assuring that beneficiaries get the information and service that they deserve.

For Fiscal Year 1988, we are proposing a Medicare and Medicaid budget of over $100 billion. This represents a net increase over 1987 of about 2 percent even after our savings proposals are taken into account. Our budget also proposes an average net increase of 8 percent per year for the next five years.

Our Medicare budget for FY 1988 includes proposals that will save $4.7 billion. 96 percent of these savings will result from changes in payments to providers and costs borne by third parties. Only 4 percent of the savings will directly affect beneficiaries.

Catastrophic Protection

I want to highlight the President's proposal to provide improved catastrophic protection for acute illness in Medicare. This proposal, which is the product of a major effort led by Secretary Bowen, was transmitted to the Congress last fall. I know you are very interested in the financial protections that this proposal will offer to beneficiaries.

Today, only a very small number of elderly enjoy the peace of mind that comes with knowing that they are protected from the financial disaster of a catastrophic illness. While Medicare provides basic acute care protection, there are still gaps that often are not realized until a serious illness occurs. For example, Medicare requires beneficiary payments for hospital and physician deductibles, part of the cost of hospital care after 60 days and full cost after 150 days. In addition, beneficiaries must pay 20 percent coinsurance for all physician services and coinsurance for skilled nursing facility care. Out of 30 million Medicare beneficiaries, approximately 1.2 million will incur personal costs for acute care of $2,000 or more in 1987. While many beneficiaries purchase supplemental policies, even these do not always provide coverage for more serious illnesses.

Under the President's and Dr. Bowen's plan, for an additional small premium per month, beneficiaries will be covered for approved out-of-pocket costs for covered services that exceed $2,000. As part of the added protection, all hospital and skilled nursing facility coinsurances would be eliminated. No beneficiary would ever pay more than two hospital deductibles in any year, and skilled nursing facility care would be fully covered for 100 days each year. The complicated "spell-of-illness" concept would be eliminated.

This would be the first major new protection in the basic benefit package since the Medicare program was introduced. This added protection also makes the Medicare benefits function more like private insurance and thus makes it easier for beneficiaries to understand what services are covered and their liability for out-of-pocket costs.

Quality Health Services

I would like to discuss one of our highest priorities -- assuring access to quality care.

While we believe that the professionalism of physicians and health care providers will in almost all cases assure that quality of care is protected not only for the elderly but for all patients, we believe that government has a responsibility to monitor quality and to take appropriate action when problems are found. Our budget for Medicare and Medicaid makes a strong commitment to ensuring quality of care in all settings.

The 1988 budget includes approximately $176 million for activities of Peer Review Organizations (PROs) in 1988. We are examining reprogramming of additional funds for new tasks mandated by the Consolidated Omnibus Reconciliation Act and the Omnibus Budget Reconciliation Act of 1986. The PRO scope of work emphasizes quality of care review. This review includes subjecting all cases reviewed to a comprehensive set of quality screens; focusing review on specific problems; and strengthening the intervention process when quality problems are found. PROs will work to correct these problems, including denying payment, whenever they find a situation where they can document substandard care.

In addition, we are implementing a new quality review process for beneficiaries who are enrolled in health maintenance organizations and competitive medical plans. This review will provide an independent assessment of the quality of care of both institutional and ambulatory services provided by these risk contractors. We intend to penalize plans that fail to honor their commitments to the elderly beneficiary or to the government. We are proposing legislation to increase the penalty for failure to provide medically necessary services from $10,000 to $25,000. We are also proposing to assess civil monetary penalties and intermediate sanctions against HMOs and CMPs that overcharge, inappropriately screen out or disenroll Medicare beneficiaries, or misrepresent their private enrollment.

Funding for the state survey and certification program, which reviews the health and safety of institutions that participate in the Medicare and Medicaid programs, is requested at $123 million in 1988. This is an increase of 15 percent over the 1987 level and 38 percent higher than 1986. An important new activity is the change in emphasis of our reviews to monitoring the outcomes of care. In addition, we are adopting many of the recommendations from the Institute of Medicine study for improving the quality of care in long term care facilities. We are planning to propose new conditions of participation for nursing homes and new rules for the survey and certification process in the near future.

One of the recognized problems with monitoring quality of care is that it is often difficult to distinguish bad care from different styles of practice. Therefore, we are committing $7 million of our research budget to improving our knowledge in the area of quality studies. We will be looking at the development of quality measures for different settings; supporting a national study of care provided to Medicare beneficiaries after they are discharged from a PPS hospital; and studying the variations of medical practice in different geographic areas.

Private Health Plan Option

This year we are proposing a major initiative to give beneficiaries and providers broader opportunities to participate in Medicare and Medicaid through a private health plan option.

We believe that there is a better solution to the economic and delivery problems of health care for the elderly -- this is the managed care approach. Coupled with per capita payments, managed care helps to provide incentives for providers and physicians to look after the entire range of a patient's health care needs and to assure that care is provided in the appropriate setting. This continuity of care, which we believe is higher quality care, is very difficult to accomplish under our current payment and delivery systems.

Our approach is to offer beneficiaries the choice of participating in an expanded range of private health plans.

Currently, Medicare beneficiaries can choose the traditional fee-for-service system or join a health maintenance organization or competitive medical plan. From the beneficiary perspective, alternative plans such as HMOs and CMPs have proven to be an effective way to broaden health coverage and/or reduce out-of-pocket costs. During the first year of our Medicare HMO risk-contracting program, over 90 percent of the plans offered enrollees additional services not covered by traditional Medicare programs, such as preventive services, prescription drugs, and catastrophic coverage. Enrollees in these plans pay considerably lower out-of-pocket costs -- $22 per month compared to the approximately $38 per month paid by beneficiaries in the fee-for-service sector. We believe that broadened use of these managed care systems will mean that more elderly will receive more health care coverage for their medical dollar.

I would like to emphasize that it has never been our intent to "push all Medicare beneficiaries into capitated plans." Our policy is voluntary choice.

For Medicaid, we propose to spur the growth of managed care systems by selectively increasing the Federal matching rate for a three year period. This financial incentive will help cover the increased costs associated with starting up new contracts for managed care.

Promoting Competition and Efficiency

Our budget includes a number of proposals that will promote increased competition and efficiency among health care providers. We believe that a competitive system sharpens the industry's incentives for efficiency without comprompising quality. I would like to highlight several proposals.

- Physician Payment Reforms - Our budget includes proposals to reduce Medicare payments for overpriced procedures and adjust the payment methodology for new physicians so that they are not overpaid relative to established physicians. We are proposing to establish a more reasonable rate for cataract surgery. We propose to move away from inherently inflationary fee-for-service reimbursement for radiology, anesthesiology, and pathology (RAP) services. Under our proposal, payment would be based on an average rate for RAP services associated with a specific procedure. These physician payment reforms would provide incentives for physicians to provide medically necessary quality care while at the same time reducing part B premium costs to beneficiaries.

- Modify Prompt Payment Timeliness Standards - The Omnibus Budget Reconciliation Act of 1986 established timeliness standards for the payment of Medicare Part A and Part B claims. We are submitting a legislative proposal that would extend the 1987 ceiling of 30 days for clean claims to 1988 and beyond. In addition, we would establish a 28 day floor. We believe that a 30 day payment cycle is a policy that is not only reasonable but is both sound and commonly accepted in the business community. Our proposal results in budget savings that help us avoid cuts in beneficiary care. Although we do not believe our proposal will cause financial hardship, beneficiaries can be protected entirely by choosing a physician or supplier who accepts assignment.

Without legislation, our FY 88 policy is to pay clean claims within 26 days, but no faster than 24 days. Our FY 1987 policy is to pay claims on an average of 20 days which we currently plan to achieve by paying electronic claims no faster than 5 to 7 days.

Beneficiary Participation

In addition, our budget includes several proposals that will modestly increase Medicare beneficiary financial participation in the program. Medicare has always required beneficiaries to share in the costs of the program as do most private insurers. This cost-sharing includes the payment of premiums, deductibles, and coinsurance. While these costs have increased in recent years, they have not increased in proportion to the increases in expenditures for Medicare benefits.

We understand and share a reluctance to impose any hardship on our most vulnerable elderly. However, it is important to remember that most beneficiaries have supplemental insurance policies that will provide protection for premium, deductible, and co-insurance costs required by Medicare. Payments for deductibles and co-insurance would be counted towards the $2,000 catastrophic cap. In addition, the lowest income elderly are protected by Medicaid. We believe that the additional costs that will result from our proposals are minimal, and that a modest cost-sharing level is a legitimate means of ensuring appropriate utilization of services without undue hardship for beneficiaries. I will briefly summarize the changes we propose to make.

o Medicare Part B Premium - We are proposing to restructure how the Medicare part B premium would be set. This change would create a more equitable balance between general revenue and premium financing of the part B program consistent with the original intent of the Medicare program. Our proposal would establish three categories of payers: current enrollees; new beneficiaries (entitled as of January 1, 1988); and beneficiaries whose premiums are covered by third-party payers. The premiums for current enrollees would be set at 25 percent of program costs, thus extending permanently the current provision of law that expires at the end of 1988. For new enrollees, premiums would be set at 35 percent of program costs beginning in 1988. For third-party payers, the premium would be set at 50 percent of program costs.

- Medicare Part B Deductible - We are also proposing to amend the statute to index and automatically update the part B deductible to changes in the Medicare Economic Index beginning in 1988. The annual deductible is now $75 and has only been increased twice since its original $50 level in 1966. We expect our proposal to cause the deductible to rise by a modest $2 in 1988.

- Full Month of Eligibility - Under current law, Medicare eligibility begins on the first day of the month in which the beneficiary turns 65. The 1988 budget includes a legislative proposal to begin eligibility on the first day of the month after an individual turns 65. This proposal should not result in a lapse in health insurance coverage since most beneficiaries have private policies which cover expenses until the beginning of Medicare entitlement.

- Include All State and Local Employees Under Medicare - All state and local employees hired after March 31, 1986 are now included under Medicare. Our proposal would make Medicare coverage and Hospital Insurance taxes mandatory for all state and local employees hired before March 31, 1986. This change will ensure that Medicare coverage is available to state and local government workers who now have no opportunity to enroll.

Improved Management

We are also moving to improve the management and efficiency of the Medicare and Medicaid programs and our beneficiary services.

We propose to control the growth of the Medicaid program, which is still growing at three times the rate of general inflation, by imposing a limit on payments to states.
This growth limit will promote better management while providing states with a number of incentives which will assist in cutting costs. States will have greater flexibility to design and operate their medical assistance programs by targeting services to specific groups, by implementing innovative ways of financing and delivering services, and by providing services on a less than statewide basis. If states implement efficiencies, they should

be able to continue to provide services they are currently providing. A special $300 million contingency fund would be available in 1988 for states which, despite aggressive cost control efforts, have costs well in excess of their ceilings.

We are also improving our services to beneficiaries.

- In December we required PROs to review beneficiary appeals of notices of discharge from a hospital on a more timely basis. Our instructions protect beneficiaries from financial liability until the PRO decision is complete.

- Shortly we will send beneficiary and provider groups a copy of our revised notice, entitled "An Important Message About Medicare". We will send this notice to PPS hospitals for distribution to all Medicare beneficiaries who enter a hospital. This revised notice provides new information about availability of post-hospital benefits and financial liability for beneficiaries who appeal their hospital discharge decision.

- We expect to notify beneficiaries in connection with their April social security checks that they can receive a copy of the directory of participating physicians free of charge upon request to their carrier.

- We have just completed a project to make sure that our notices to beneficiaries are clear and understandable. Carriers are now revising forms and notices that we send to beneficiaries.

- We have improved our toll-free carrier telephone service by installing new equipment that can monitor waiting times and we have issued guidelines on how to answer inquiries.

We believe that these activities underline our commitment to be a fair business partner to beneficiaries. We know we can do a lot more to help beneficiaries understand a very complex program and it is our intent to work with beneficiary groups to accomplish this task.

Conclusion

Our 1988 proposals provide the elderly with important financial protections and assurance that there will be access to quality health services. Our catastrophic proposal provides beneficiaries with financial protection for out-of-pocket costs. Our private health plan option offers increased choice and the opportunity for beneficiaries to share in the benefits of the efficiencies of managed care. And our investment in quality of care protections means that changed financial incentives will not result in a lower standard of care.

I will be pleased to answer any questions that you may have.

The CHAIRMAN. Are you equating a $6 billion cut with better service?

Dr. ROPER. First let me say, Senator, that the $6 billion figure—$4.7 billion from Medicare and $1.3 billion from Medicaid—are reductions from the rapidly rising baseline for these programs. It's a reduction from the rate of increase. And yes, I'm saying that we will deliver better service with those savings.

The CHAIRMAN. Is a 1-month gap part of those savings?

Dr. ROPER. Yes, sir, a delay in eligibility for the program from the current law——

The CHAIRMAN. How much does that save? Half a billion?

Dr. ROPER. It will save $295 million next year.

The CHAIRMAN. A third of a billion. Well, why stop with 1 month, then? Why not make it 6 months and save $1.8 billion?

Dr. ROPER. Because under the current framework, most beneficiaries are protected for that month already.

The CHAIRMAN. They are?

Dr. ROPER. As they retire, their employment-based benefits typically carry them to the end of the month in which they retire, and in 90 percent of the beneficiaries, that is the case.

The CHAIRMAN. How many?

Dr. ROPER. At least 90 percent.

The CHAIRMAN. That's 90 percent?

Dr. ROPER. Yes, sir.

The CHAIRMAN. You've got a study that shows that?

Dr. ROPER. Yes, sir.

The CHAIRMAN. I suppose that study cost about $30 million to show that.

Now, if there is double coverage, then why do you think they're going to put it on Medicare? Why wouldn't they just put it on that Blue Cross or whatever policy they had?

Dr. ROPER. Because as long as Medicare begins coverage, as it now does, on the first of the month in which a person retires, that's a savings to the Blue Cross plan.

The CHAIRMAN. Yes, but who decides that?

Dr. ROPER. The law as it now stands has decided that.

The CHAIRMAN. At the age of 65 everybody's got a Blue Cross policy for 1 month? You're telling me that the law requires them to hook Medicare for it?

Dr. ROPER. No, but the law covers Medicare beneficiaries from the first of the——

The CHAIRMAN. Right, for a good reason.

Dr. ROPER [continuing]. Month in which they——

The CHAIRMAN. For a good reason.

Dr. ROPER. No, sir, that is the law that was passed 21 years ago.

The CHAIRMAN. Yes, for a good reason, because we didn't want a gap to exist for the 10 percent or whatever it is—whether your study is accurate or not—that would have a gap. What did your studies show on how many of those people just put the charge to Blue Cross, or whatever the private carrier is? Didn't your study look for that?

Dr. ROPER. I assume that what Blue Cross does is end its coverage at the end of the month before the person becomes 65. That is the savings that they are entitled to under the law as it now stands.

The CHAIRMAN. I think you're avoiding that. Didn't your study show whether they put their bill in to Blue Cross or Medicare at that particular month?

Dr. ROPER. I'd be glad to check that and give you an answer for the record, sir.

The CHAIRMAN. You really don't know, then.

[Subsequent to the hearing, the following information was received for the record from Dr. Roper:]

The surveys that we used to support our proposal on Medicare eligibility do not address the question of coordination of benefits. Thus we have no information on how beneficiaries file claims when there is duplicate coverage.

A survey conducted by the Public Health Service was used as the basis for our proposal. The National Medical Care Expenditure Survey conducted in 1977 found that 92 percent of persons age 64 had health insurance. 84 percent of the insurance was private (of which 69 percent was work related) and 8 percent was publicly financed insurance (including Medicaid, Champus and other public programs).

The more recent date from the Census Bureau (data from the Survey of Income and Program Participation conducted during the early 1890's) reviewed health insurance coverage for a broader age group (ages 55–64) and found that 89 percent had coverage.

An informal survey of private health insurance policies revealed that most private employer policies cover the retiree until the end of the month when they retire or when Medicare entitlement begins. Thus, there often is duplicate coverage, at least for persons who retire during the month of their 65th birthday.

The CHAIRMAN. Nevertheless, there would be a gap for anybody whose insurance ceased as of the moment that they went on Medicare. And what are those people supposed to do?

Dr. ROPER. Make arrangements to continue their coverage until the end of the month after they retire.

The CHAIRMAN. Can they do that?

Dr. ROPER. Yes, sir.

The CHAIRMAN. How do they do it?

Dr. ROPER. By employers changing the way they cover their retirees.

The CHAIRMAN. Have they done that?

Dr. ROPER. No, sir, because——

The CHAIRMAN. Wouldn't you want them to do it before you left somebody uncovered?

Dr. ROPER. We would ask that they do it after you pass the change in the law because there is time for them to make those adjustments in the employment-based plans. This is similar to other changes that you've made in previous years, such as——

The CHAIRMAN. Aren't we just shuffling a quarter of a billion dollars from one pocket to another?

Dr. ROPER. It's a savings to the Medicare Program.

The CHAIRMAN. A savings to the Medicare Program and it's a cost to everybody else. Who pays for Medicare if everybody doesn't pay for it?

The only point I'm trying to make, Doctor, is that what you're suggesting is unworkable and couldn't possibly be approved in this Congress unless there was some assurance that there isn't any gap.

Dr. ROPER. You've made similar changes in the past, sir, for example, requiring that working elderly over the age of 65 seek payment under their employment-based insurance, rather than Medicare, first. And once you enacted those changes, the private market altered their insurance policies for their workers, and they would do the same thing under this.

The CHAIRMAN. I think you're describing something, though, that did not create a gap.

Dr. ROPER. Yes, sir. It said that Medicare would be the second coverer, and that employment-based plans had to step in and become the primary coverer.

The CHAIRMAN. So you're telling me that you created a gap, or you just had a time when everybody was covered—either with their private coverage or Medicare—and you made a change then without creating a gap, if I understand you correctly?

Dr. ROPER. Once the Congress enacted the change I'm referring to, the employers altered their plans to provide coverage as they needed to for their workers. And a similar sort of thing would happen under this circumstance.

The CHAIRMAN. But this will create a gap if the coverage ceases at age 65, and that's what we will have to seek to avoid. I hope you would understand that, Doctor.

Isn't there a question about catastrophic—Dr. Bowen's proposal that has been presented—that adding as a Part B cost along with a raise in Part B, as you would suggest—isn't there some reason to fear that some people might not take Part B, then, because of the double cost increase?

Dr. ROPER. The current Part B premium is roughly $18 a month. The increases that are proposed are really very modest increases, given the dramatic enhancement in the program that they bring. And we'd expect the numbers who enroll to stay at the very, very high level, 97 percent currently.

The CHAIRMAN. And do you have any sampling like the other study on the 1-month gap?

Dr. ROPER. Do you mean estimates of how many beneficiaries would choose to stay enrolled, opinion polling?

The CHAIRMAN. Yes.

Dr. ROPER. No, sir, we have not done that.

The CHAIRMAN. It could be risky, then, in getting the catastrophic off the ground, could it not?

Dr. ROPER. We are anxious to present a program enhancement and a way to finance it, and the Secretary and the President and I think this is a very satisfactory way of achieving both of those goals.

The CHAIRMAN. The Medicaid cap would effectively pass on any additional costs for Medicaid to the States and the counties, would it not?

Dr. ROPER. States would incur additional costs if they chose to continue to operate their programs as they currently do. But the other part of the cap is dramatic enhancement of State flexibility to manage their programs more efficiently. Currently, they are hamstrung by a number of Federal requirements for these programs; given sufficient latitude, they could make the dollars—even the dollars under the cap—go much farther than they currently do.

The CHAIRMAN. Well, what's wrong, then, with looking at the hamstringing and taking that off rather than establishing the cap?

Dr. ROPER. Because this is part of a well thought-out budget that meets the Gramm-Rudman-Hollings targets that you all passed.

The CHAIRMAN. I think that's the thrust of it, is how many bucks are going to be taken out of your department with Medicare and Medicaid to pay for some other things. It's a question of priorities, isn't it?

Dr. ROPER. It's a question of coming up with a reasonable budget, and I'm sure that's what you're looking at, as well.

The CHAIRMAN. Isn't it a question of priorities?

Dr. ROPER. Yes, sir.

The CHAIRMAN. I think so.

And then we get to the fairness question, but I'm not going to embarrass you with asking about that.

You mentioned these requirements. I think you said you spent some money, 7 percent of your research money——

Dr. ROPER. Twenty percent.

The CHAIRMAN. Twenty percent?

Dr. ROPER. Yes, sir.

The CHAIRMAN. Well, for $7 million, is that correct?

Dr. ROPER. Yes, sir.

The CHAIRMAN. Was that——

Dr. ROPER. On quality of care research.

The CHAIRMAN. Quality of care research?

Dr. ROPER. Yes, sir.

The CHAIRMAN. Has there been anything done to lessen the paperwork that everybody complains about, whether it's a physician's office or a hospital?

Dr. ROPER. We've taken several administrative steps to lessen the paperwork burden that physicians and others face.

The other part of the paperwork burden that we're anxious to deal with is the burden that beneficiaries face. The complaint that I hear continually from people on Medicare, including my father, is that the paperwork that they face is maddeningly complex. And we are anxious to simplify that. The major initiative that we have in that regard is our desire to offer beneficiaries the option of participating in private health plans that have substantially reduced paperwork. That's one of the major reasons people over 65 want to join those kinds of private plans.

The CHAIRMAN. I encourage you in that work on all fronts, both with the patients and their physicians and the hospitals.

Thank you, Doctor.

Senator Heinz.

Senator HEINZ. Thank, you, Mr. Chairman.

Dr. Roper, first, on the Medicare Program. The Administration's budget assumes that the hospitals are going to receive an increase of 1.5 percent in their DRG payments.

Dr. ROPER. The budget as put forward has it at 1.5 percent, yes, sir.

Senator HEINZ. ProPAC has just approved a recommendation of 2.3-percent average increase. Do you think that it's possible, given the fact that we have granted lower-than-recommended increases each year, that we are getting to the point where the law of diminishing returns operates. In effect, having trimmed the fat are we eliminating the ability of the hospitals to keep up with new technology and respond to the needs of their patients? Have we reached that point? And if not, how do you know?

Dr. ROPER. I understand your question. We continually seek to pay appropriate levels—not too much, but certainly not too little—under the current law. The Secretary must report to the Congress by April 1 on what his recommendation for fiscal year 1988 will be. The 1.5 percent that you mentioned earlier is the figure that's in the budget; but by the end of the month he will be reporting to you on what the——

Senator HEINZ. And the Secretary may or may not report 1.5 percent in his recommendations?

Dr. ROPER. Yes, sir. That is a number that was put in for budget planning purposes, but his figure will be based on his determination of what the appropriate figure ought to be.

Senator HEINZ. Let's move off of that subject because it will be discussed at another date, probably in the Finance Committee or here.

Let me ask you this. I spoke in my opening statement about the fact that the elderly are paying about the same proportion of their health care costs out of pocket today as they were 23 years ago, before we enacted the Medicare Program, and the Medicaid Program, for that matter.

Yet, in the proposed budget, cost-sharing by the elderly will increase by roughly $13.7 billion over the next 5 years principally in the form of Medicare premiums. Some of the increase will also come from escalating co-payments, most of the latter being defined by existing law, as I understand it.

My question is really this. As we increase co-pays or premiums, is there any evidence that those kinds of additional beneficiary costs will result in higher total Medicare outlays because the increase in out-of-pocket costs will cause the elderly to delay seeking health care? They might say, for instance, "Well, I can't afford that 20 percent of the doctor bill, and I'm just going to wait until I can't make it any longer and then I'll go see the doctor, and maybe this lump I've got—maybe I don't need to worry about it." Time can be a very important factor in treatment costs. I'm told, for example, that osteoporosis, while apparently at this point is not reversible, is arrestable if diagnosed early, and that certain kinds of care can prevent the pain, agony, and extraordinary cost to Medicare of hip surgery, whether it is joint replacement or simply putting the knob back on the femur.

Do we have any evidence about the law of diminishing returns there?

Dr. ROPER. No, sir, we don't. I'd just point out two things, though. The current level of premiums and cost-sharing, the copayments under the Medicare Program, in real dollars are dramatically lower than they were when the program was originally passed back in 1965. The level of premium increases over the years has not kept up with inflation. But it's because of the concern that you've voiced that the Secretary and the President have put forward the catastrophic proposal that would place limits on cost-sharing at $2,000.

Senator HEINZ. Let me ask you about the premium. As I understand it, next year for new enrollees in the Medicare Program, the

Part B premium—instead of being 25 percent of program costs as it is for current enrollees, would be 35 percent. About one-third of all Medicare beneficiaries are just about at, or only slightly above, the poverty level. What do you say to those people who say that you are taxing the poor equally with the rich, and that this particular proposal is therefore highly regressive? And also unfair because downscaled Medicare beneficiaries are probably going to go to less expensive doctors than upscale Medicare beneficiaries.

Dr. ROPER. Well, the impact on the poorest would be mitigated to a great extent by the fact that they'll be covered under the Medicaid Program. The increase from 25 percent to 35 percent of program costs is really a modest increase that we feel is warranted. Again, under the original design of the program, the premium was to be 50 percent of the program costs.

Senator HEINZ. Modesty is always in the eye of the beholder, as pictures of bathing suits going back over the past 100 years prove. My question is, irrespective of whether it's $100 a year or $1,000 a year, the question of principle is still involved. Is it regressive or not?

Dr. ROPER. A level premium affects those who are the poorest the most, yes, sir.

Senator HEINZ. And you see no way to cope with that at this point?

Dr. ROPER. There are some ways; to change the level of the premium——

Senator HEINZ. Well, I'd like to get into those at greater length.

Let me ask you one last question before my time expires, and that is on the Medicaid cap which will save $1.3 billion in 1988 and, as I understand it, about $16 billion over the 5-year period, a big chunk of money. The Medicaid Program, somewhere between one-third and one-half of which pays nursing home bills for the elderly, is an entitlement program. It is for people who are so poor they have no place else to go except onto Medicaid.

There are only three ways I know of to get savings from an entitlement program by capping it. First, you can decrease the number of people in the program. Well, it is projected that there will be 441,000 more eligible beneficiaries in Medicaid next year than this. Second, you can reduce payments to the provider. I don't know of many people who argue that Medicaid payments to the provider are overly generous, but maybe you can talk to that. The third is that you can reduce services to the beneficiary.

With which of those three mechanisms, or in what combination, do we expect the Administration's block grant (by capping the program, the proposal is, in effect, a block grant) to operate?

Dr. ROPER. There's a fourth option, and that is that the States would operate the program more efficiently. I mentioned in my comments to Senator Melcher that the other part of the cap is giving the States substantially more discretion so that they can do that. Not cutting services, not cutting payments to providers, but such things as building incentives for patients to be treated appropriately as outpatients instead of inpatients; those kinds of things that you've been a pioneer in urging us to do in the Medicare Program can be done as well in the Medicaid Program.

Senator HEINZ. And there is a lot of evidence that $16 billion worth of efficiencies are there to be had?

Dr. ROPER. We think there are, yes, sir.

Senator HEINZ. Is there an analysis of that?

Dr. ROPER. There's an analysis of the first year figure and an assumption that, over time, the States will be able to make other savings.

Senator HEINZ. We are finding that in the Medicare Program savings are getting harder and harder to get simply by capping the rate of increase of reimbursement of hospitals, because there's only so much in the way of efficiency to be gotten at before hospitals start doing some things we'd rather not have them do, such as discharging people into the community without appropriate provision for home health care or nursing home care. Would you not want to be very careful and know what's going to happen in the third and fourth and fifth year, because there's a lot of evidence to suggest that what is happening in the Medicare Program right now—which we're trying to do something about—could very easily happen in the Medicaid Program? Remember, the Medicaid Program doesn't let anybody drop through the cracks; it is an entitlement program, and we do track people pretty carefully. Medicaid, under your proposal, becomes a block grant. We lose those people on our radar screens.

Dr. ROPER. You are absolutely right. This needs to be done carefully and monitored over time. When I was here before the committee last June I mentioned my desire to move us further along, much further along, in our ability to truly measure what quality health care is, and to monitor that quality. I've made substantial progress on that score and would be happy to discuss it with you at length, but I think we are close to being able to put some real statistics to the test, to say not just that we guess that quality is up or down or sideways, but what the true story is. And that's my desire, to make sure that what we're doing is appropriate.

Senator HEINZ. I think my time has probably expired. If it hasn't, it should have. [Laughter.]

The CHAIRMAN. Thank you, Senator Heinz.

Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

Dr. Roper, I know that you're aware of the 37 percent rise in patients leaving hospitals and requiring home health care since Medicare payment limits went into effect, I believe, in 1983. But Medicare-covered home care visits have increased only 8 percent, according to the figures that we have.

According to the GAO, whether a patient is granted coverage for home care depends largely on which of the 47 insurance companies nationwide that reviewed the claim. It seems to me that with 3.2 million elderly in need of regular home nursing care or other care to live at home—and with only three-fifths of these seniors getting the help they need—something is wrong.

I'm basically referring, Dr. Roper, to the unwritten and unpublished guidelines that are limiting elderly access to the Medicare home health benefit. My question to you is this: When is HCFA going to establish a permanent set of criteria, eligibility that clearly states the circumstances that entitle a patient to home care?

And second, does care by family members who freely supplement Medicare-covered services jeopardize the patient's eligibility for this care? And three, how can you explain the 133-percent jump in Medicare denials for home health claims from the first quarter of 1984 to the first quarter of 1986?

Dr. ROPER. Thank, you, Senator. Let me try to take the second one first.

Does family provided care somehow make a person ineligible for Medicare? Absolutely not. We encourage families to offer care to their loved ones; that's important not only for——

Senator SHELBY. It doesn't make them ineligible?

Dr. ROPER. No, sir. Not at all.

Senator SHELBY. OK.

Dr. ROPER. Your third question, how do we explain the increased number of denials from 1984 to 1986, it is because, No. 1, the number of home health services are going up rather dramatically and program expenditures are going up. But we instituted in the fall of 1985 a better, more careful management of the program using enhanced information on just what the individual patient circumstances were, and that has led to more accurate coverage decisions on our part.

The GAO report you referenced does make two big points. One is that we, HCFA, ought to do a better job of administering the home care benefit. They thought we were being too loose with that program, and we are taking steps—like the one I mentioned, and others—to do that. They also raised the question about, are the elderly getting all the services they need? And we're looking at that, as well.

If I could add one other point, you mentioned the fact that across the Nation there is at times some inconsistency in how this program is administered. We are aggressively moving to solve that problem by having only 10 intermediaries to process home health claims nationwide, thereby giving us much better quality of service and much more consistency.

Senator SHELBY. Doctor, with respect to the private health plan option, how does HCFA propose to insure coverage for home health costs for enrollees?

Dr. ROPER. By the arrangements that the private plan—wherever it is, whoever it is—the arrangements that they make with home health agencies who deliver that care.

Senator SHELBY. I want to ask you a couple of other questions, getting into another area.

Physician payment reforms—you're familiar with it?

Dr. ROPER. Yes, sir.

Senator SHELBY. Do you think this is really going to save a lot of money? And if it does save a lot of money, will it be at the expense of the elderly as far as quality is concerned?

Dr. ROPER. Our proposal would save $10 million in fiscal year 1988 and about $500 million over the 5 years of the budget. That's not billions, but that's an important savings.

Senator SHELBY. You said $10 million?

Dr. ROPER. In fiscal year 1988.

Senator SHELBY. Why only $10 million the first year?

Dr. **Roper**. Because we propose to implement it only for the last quarter of the fiscal year.

Senator **Shelby**. OK. And then jump from $10 million to $500 million?

Dr. **Roper**. Over 5 years.

Senator **Shelby**. Over a 5-year period. In other words, about $100 million a year?

Dr. **Roper**. Roughly that, yes.

Senator **Shelby**. And how would that work?

Dr. **Roper**. The proposal would pay for radiology, anesthesiology, and pathology services for hospital inpatients under a DRG framework. We would pay a lump sum for those services instead of paying those doctors for those services individually.

Senator **Shelby**. You pay the lump sum? You write one check to the hospital, is that correct?

Dr. **Roper**. Well, that's one way it could be done. Another way would be to write a lump sum check to the medical staff of the hospital.

Senator **Shelby**. And then they have to fight over it and decide who's going to get what out of it? Is that what you're doing?

Dr. **Roper**. They would have to divide it up appropriately.

Senator **Shelby**. Divide it up appropriately.

Have you heard from a lot of the practicing physicians regarding their concerns about it being divided up inappropriately?

Dr. **Roper**. I've heard concerns expressed on that, yes, sir.

Senator **Shelby**. Will this move the health care delivery more and more to the hospital, and the control economically of health care through the various hospitals, private and otherwise, as opposed to the doctors?

Dr. **Roper**. Well, first of all, we're talking about hospital services rendered by physicians——

Senator **Shelby**. That's health care, though, isn't it?

Dr. **Roper**. Well, it is, certainly. But under the scenario you paint where the payment would go to the hospital, it would indeed add to the hospital's power. Under the other alternative of paying physicians, it would maintain the current relationship between hospitals and doctors.

Senator **Shelby**. But you've got figures showing $500 million in savings?

Dr. **Roper**. That's our estimate, yes, sir.

Senator **Shelby**. Will this be at the expense of health care in any way, the quality of it? Could it impact on health care?

Dr. **Roper**. We don't think so.

Senator **Shelby**. You don't think so.

That's all I have, Mr. Chairman.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Mr. Chairman, thank you.

Ever since cable came to our home, I appreciate CSPAN a lot more.

I wonder, Dr. Roper, if we couldn't back over the so-called budget cuts, and I think the Chairman asked you how you justify future cuts, and you responded that they were sort of a retardation in the growth, so to speak. And if I look at the figures that I have before me, prepared for us by the minority side here, in the current year we're spending $71.6 billion on Medicare, and you propose to increase that to around $73 billion. NIH about stays the same. Social Security, which a lot of people use to pay for their health care, goes up from $208.5 billion to almost $220 billion. SSI goes up $10.9 billion to $12.3 billion, and I could go on.

But one of the cuts here clearly is in Medicaid, and I'm sure you're going to hear a lot more about that when you get to the Finance Committee as well, but the reality is that the Administration is not proposing to cut expenditures for health care, but it is very clearly putting some clamps, if you will, on certain areas of growth. And I wonder if we couldn't explore that just a little bit; and again, perhaps for our mutual education.

In the area of Medicare payments we find things that don't go to older people in terms of care. We have something, don't we, called a "disproportionate share hospital"——

Dr. ROPER. Yes, sir.

Senator DURENBERGER [continuing]. And do we—is it not true, and maybe you can explain to us—that we incorporate into payments out of the Medicare trust fund, payments to certain hospitals not on the basis of how many elderly patients they have, not on the basis of how many elderly or Medicare-eligible visits there are, but strictly on the basis that they have a very high Medicaid population? General hospitals, public hospitals, big city hospitals, and so forth, that when we moved into this prospective payment system, besides having a lot of elderly, we also had a disproportionate share of the poor.

So a fair amount of Medicare money is, in effect, going to pay hospitals an extra amount of money just because they take care of poor. Could you describe that for us a little bit?

Dr. ROPER. Yes, sir. That's a provision of the COBRA legislation Congress passed last year, and it is as you described it, an additional payment to hospitals because of the mix of their patients and the income status of their patients. But we believe, as we testified earlier, that that is not an appropriate expenditure of Medicare funds, and one of our budget proposals is to save about $1.2 billion in fiscal year 1988——

Senator DURENBERGER. Do you know about how much we are spending for these so-called disproportionate share payments, and how much you want to save—you want to save about $1 billion out of that, or $1.3 billion, I think. Do you know what the total is that we're paying in that category?

Dr. ROPER. I'd be glad to get it for you.

[Subsequent to the hearing, the followng information was received for the record from Dr. Roper:]

Our proposal does not eliminate the disproportionate share adjustment for hospitals. Rather, our proposal is to eliminate the special retention of the Periodic Interm Payment (PIP) system for certain hospitals that qualify for a disproportionate share adjustment. Under our proposal, these disproportionate share hospitals would be paid under the same prompt payment standards required for other PPS hospitals. (Certain small rural hospitals would continue to receive PIP.) The savings would result from a shifting of $1.2 billion in payments from fiscal year 1988 to fiscal year 1989. It is essentially a cash flow change.

Senator DURENBERGER. There's another one called "graduate medical education." That's where we educate a lot of doctors so that we can have more doctors in this country than we really need. But we have to have doctors, and it costs a lot to educate doctors.

Now, is it not true, Dr. Roper, that part of the change in this Medicare reimbursement system, that we made a commitment on behalf of the elderly and on behalf of our obligations under the trust fund to ensure that there would be adequate training in America for doctors, and so first we created something called "indirect medical education," and that's one account, and then most recently we have payments called "graduate medical education." And, in effect, that compensates those teaching hospitals that provide graduate medical education for the doctors of America. Not necessarily payments for benefits provided for the elderly, but payments to hospitals for educational costs of educating doctors. Is that not true, and can you give us a little dimension of that one?

Dr. ROPER. Sure. You remember when Medicare was passed in 1965, the additional payments that you mentioned were built into the system. The language that went with the statute in 1965, though, said that this was to be done until society made other arrangements to pay for medical education.

I share your view that that's an important function for us to continue as a society; however, it needs to be rethought in the context of the fact that we have dramatically more physicians trained and currently in training than we used to have; and, I think most people would agree, reduced needs for additional doctors. And for that reason we have put forward two proposals, one to reduce how much we pay for direct medical education costs and second, a reduction in how much we pay for the so-called indirect medical education cost add-on. We think those are prudent because we need to be careful how we spend Medicare's precious dollars.

Senator DURENBERGER. So out of the $4.7 billion in reductions in spending, we have $1.3 billion for these disproportionate share hospitals that take care of a lot of poor people, and we have another approximately—I think, if I'm reading this correctly—about $1.2 billion or $1.3 billion——

Dr. ROPER. Yes, sir.

Senator DURENBERGER [continuing]. In medical education accounts. Now, that gets us to the fact that a majority of the Administration's recommendations don't have anything to do with directly accessing the elderly or the disabled to hospitals, but indirectly the suggestion is to reduce the payments out of the Medicare trust fund for doctor education and hospitals that serve poor people. Would that be correct?

Dr. ROPER. That's correct, yes, sir.

Senator DURENBERGER. One of the things I don't see in here is where the Administration has dealt with all of this hospital profit that we've been reading about lately. Everybody seems to be testifying to the fact that the hospitals in this country in 1984 made a profit of 12 or 14 percent, and in 1985 about 15 percent. My sense is that that may not be totally true, but the reality seems to be that some hospitals, under the prospective payment system, are making a lot more profit than are other hospitals compared to what their profit ratios may have been before. In other words, for example, suburban hospitals seem to be doing pretty well whereas rural hospitals or downtown hospitals may not be doing too well.

Do you have any testimony with regard to that and with regard to efforts you might be undertaking to help us balance that system better between different kinds of hospitals?

Dr. Roper. I mentioned to Senator Heinz that the Secretary owes a report to you all April 1st as to what his recommendation for next year for Medicare hospital payments will be. We are currently analyzing the various things you mentioned. My good friend the Inspector General, Mr. Kusserow, has some concerns about hospital profitability. I believe that whereas hospital profits were substantially high—the figures you mentioned in 1984 and 1985—that in 1986, and certainly in 1987, we are seeing a reduction from those levels. To be very straightforward about it, we don't have good, current information about hospital profitability; and to my consternation, neither do the hospitals. I spent some days this week talking to the Federation of American Health Systems and the American Hospital Association, and they are seeking to come up with better data. But we just don't have current information.

Senator Durenberger. Thank you. I think my time has expired.

Mr. Chairman, thank you.

The Chairman. Senator Reid.

Senator Reid. Thank you very much, Mr. Chairman.

In following up on one of the questions you asked, I think we may have the salvation of the country here at our fingertips. As I heard the testimony here, the Administration is proposing to make a $6 billion cut in Medicare programs but still render better service. Isn't that the statement I heard?

Senator Durenberger. I think that's a fair assessment of Dr. Roper's testimony.

Senator Reid. I wonder if it would be possible to get you to switch to the Defense Department. We could really clean up there. [Laughter.]

We could cut that by $40 billion or $50 billion and still have better service.

Mr. Chairman, I'm concerned about a couple of things, and I'll direct these questions, of course, to Dr. Roper.

I talked earlier in my opening statement about catastrophic health care coverage. As I understand the proposals that have been introduced, including that of the Administration, none of them pick up some catastrophic health care costs which, of course, can be astronomical. Are you sticking with the Administration's proposal or a combination of some that have been offered? What do you think we should do about this complicated problem?

Dr. Roper. Certainly I believe they are sound proposals. I didn't quite understand your question, Senator. You said that the proposals don't cover catastrophic costs?

Senator Reid. Yes. We're all looking at a new way to handle catastrophic illness, and that's what all the talk has been recently. Is that not right?

Dr. Roper. One of the major concerns that has been raised, and legitimately so, is how to pay for catastrophic——

Senator Reid. Pardon me?

Dr. Roper. Excuse me. One of the concerns that has been raised, and legitimately so, is how to pay for catastrophic nursing home costs.

Senator Reid. That's right.

Dr. Roper. And the President has asked his Treasury Department to study the Secretary's recommendations for additional support for private, long-term care insurance and additional savings programs—including one called an Individual Medical Account—that would provide for more coverage of long-term care nursing home services. Those are prudent steps that ought to be followed up on.

Senator Reid. You're right, I did not read the first sentence of my question here which did say—"none of the catastrophic health care coverage proposals introduced thus far address the problem of long-term nursing care coverage," and that includes the Administration's—Dr. Bowen's—proposal; is that not right?

Dr. Roper. Well, the main proposal that has gained such attention to Medicare does not deal with nursing home services. But another part of Dr. Bowen's and the President's proposal is to study these long-term care insurance and savings proposals, and I think those are fruitful opportunities.

Senator Reid. You're saying, then, that your recommendation through the Administration is to conduct a study to see what the dimension of the problem is? Is that right?

Dr. Roper. Well, more than that, to study a couple of very promising alternatives. It's to begin with the realization that the magnitude of the financing problem of nursing home service is truly gigantic, especially with the so-called demographic trends; that is, more older people as a part of our society. It is simply not a solution, I think, to say that we shall have a Government financing program for all nursing home services. We've got to realize that this is a thing that Government and the private sector and individuals and families have to work on together. But there are some promising solutions, like the ones I've mentioned.

Senator Reid. We've been getting some letters and communications from health care providers and patients concerned about older people who are severely mentally disabled, have Alzheimer's disease, or have abused themselves with alcohol or drugs. Is there any way that Medicare could cover some of these very serious problems that older people have?

Dr. Roper. Well, of course, we do cover some parts of the care for individuals with those maladies.

Senator Reid. But—I'm sorry—when you say "some parts," what parts?

Dr. Roper. Take, for example, the Alzheimer's that you mentioned. Individuals over 65 who have Alzheimer's disease are covered for their acute medical expenses. They are not covered under Medicare for their long-term, chronic health care needs.

Senator Reid. But, of course, that is the problem, isn't it?

Dr. Roper. It certainly is. It's one I'm personally well acquainted with. One of the things we're doing at the Congress' request is launching a series of demonstrations under the Medicare Program of how better to provide services for Alzheimer's patients, and we'll be coming back to you with reports on what those demonstrations yield.

Senator Reid. That study is being conducted right now?

Dr. **Roper**. We're undertaking it under the legislation that you all passed last year.

Senator **Reid**. And how long is that going to take?

Dr. **Roper**. The demonstrations are multi-year demonstrations, but we should have results along the way.

Senator **Reid**. You also heard my opening statement when I talked about some of the Social Security field offices being closed. In Nevada, where there are such huge distances between the two metropolitan areas—that is, Las Vegas and Reno—we are very concerned that beneficiaries in rural areas will no longer be able to work with field representatives as a result of these proposed staffing reductions. Have you given any personal attention to this to determine if, in rural America, this will be a problem?

Dr. **Roper**. I believe the question you refer to is the Social Security district offices, and I defer to the representative of the Social Security Administration who will follow me. He is more able to give you a response to your question.

Senator **Reid**. Real fine. Thank you very much.

Dr. **Roper**. Thank you.

The **Chairman**. Senator Domenici.

Senator **Domenici**. Mr. Chairman, I wonder if you would permit me to just talk about an overview picture of how our country has treated the senior citizens in the past 20 years.

Senator **Chiles**. Would you yield just for a moment before you do that?

Senator **Domenici**. Of course.

STATEMENT OF HON. LAWTON CHILES, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator **Chiles**. I'm going to have to be at another hearing and I wanted to just take a minute to compliment Chairman Melcher on holding these hearings. I have had a chance to hear most of these witnesses—in fact, all of the witnesses except one, or two, that you're going to have today—at our Appropriation and Budget Committee hearings.

I trust that all of our senior citizens are going to understand that what we're talking about is the proposed President's budget. Congress has not acted on that, and I know that the Senator from New Mexico is going to talk about a history of some of the things that we have acted on.

Mr. Chairman, I want to compliment you on holding the hearings and I think they will serve good purposes, and I have enjoyed hearing these witnesses myself. I'm sorry that I can't stay.

The **Chairman**. Thank you, Senator Chiles.

Senator Domenici.

STATEMENT OF HON. PETE DOMENICI, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator **Domenici**. Mr. Chairman and Senator Chiles, I understand that you have to leave. Let me just say that last year before I left the chairmanship of the Budget Committee, it occurred to me that over the years the committee—you were my ranking member for all those years—had been addressing the issue of senior citizens and what portion of the national budget went to them. Were we really, in a sense, addressing the senior citizen issue with financial resources, or were we making the senior citizens pay for something else we wanted to do in this society?

So I asked the Congressional Budget Office to go back two decades and tell us how well senior citizens had fared as part of the budget and as part of our fiscal processes. All I'm going to do is review that very quickly. I am not passing judgment on the President's program this year. We have never adopted the President's budgets in toto; the Budget Committee never has in the area of senior citizens, as you well know. I doubt that we will this year. I don't think that we've ever adopted any President's budget in the 38 years that they've been sending them to us; that's, at least, my vague recollection.

I know that Senator Chiles would join me in saying to our seniors that clearly we have not yet prepared a budget for the Congress of the United States, and it serves a good purpose to hear what the President is recommending. But we are a long way from coming to the conclusions that the collective U.S. Senate will come to, first in the Aging Committee and the Budget Committee, and then as we move through the processes.

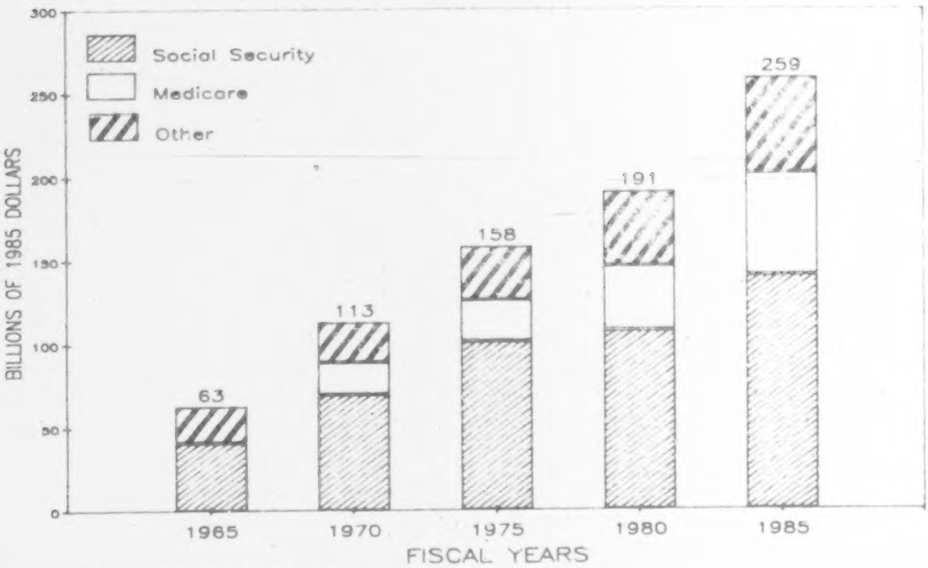
Mr. Chairman, thank you for giving me just a few moments here. I don't want anybody to think that the Senator from New Mexico is not aware of the fact that out in the United States, regardless of how much money we're spending, regardless of the number of programs that we have, that there are not many problems that remain unaddressed.

Clearly, in our kind of society when we find a major program, we fund it and we run it for 10 or 12 years and we find that some people are left out that we didn't know about, we run five or six programs concurrently and we find that arbitrary lines have been drawn, so we find that people that we thought we were helping weren't being helped. These programs are very complicated formula programs and nothing that I'm going to talk about indicates that they've reached a state of perfection, nor that we have done the absolute best job in the world putting the programs together in a way that works. We have not resolved in Medicare home health care versus hospitalization, for example.

However, I think I would conclude, Mr. Chairman, that because of the Aging Committee, its predecessor chairman, Senator Heinz, and hopefully you as you serve, others in the United States, the Finance Committees of the U.S. Congress and, yes, the Budget Committee for the last decade have done a relatively good job of funding senior citizen programs and helping the seniors of this country.

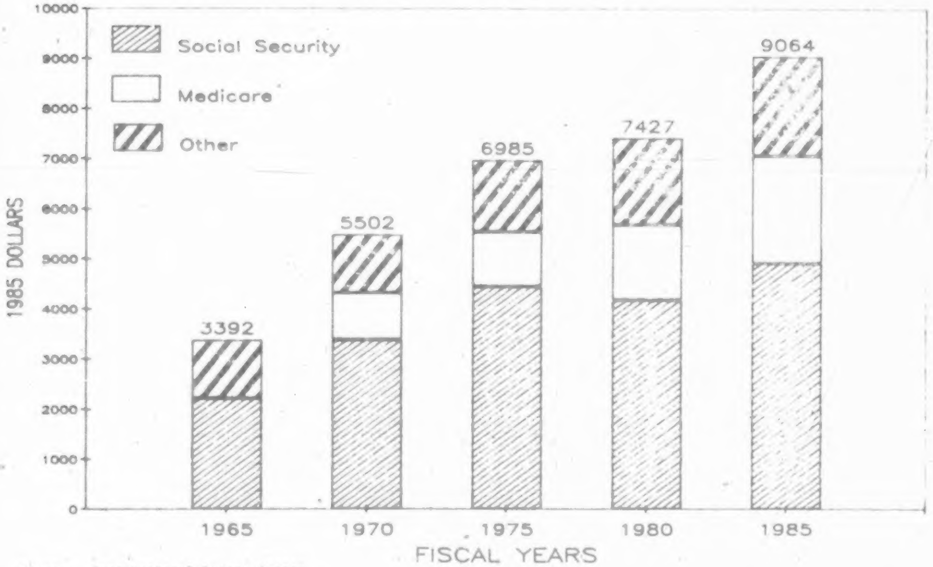
What we have in the first chart is very, very simple. In constant dollars, the first chart shows what we have spent in 1965, 1970, 1975, 1980, and 1985 for all major social programs that affect our seniors—Social Security, Medicare, and all others. It is interesting to note that in each of these decades the amount of money has gone up substantially. This is all in constant dollars. It is also interesting to note that every one of the three components have gone up dramatically; whereas in 1980 we were spending $191 billion, we are spending $259 billion in 1985.

FEDERAL SPENDING FOR THE ELDERLY
(BILLIONS OF 1985 DOLLARS)



Source: Congressional Budget Office

Now, Mr. Chairman, somebody might say, well, what are the demographics? Are there not more senior citizens now than 20 years ago? And wouldn't that graph be somewhat out of focus as to whether or not we are really, on a per capita basis, helping? So the next chart translates all these amounts into per capita assistance. That's interesting also because in 1975, per capita assistance was $6,985. In the year 1985, the Congressional Budget Office figures—not figures from any particular committee around here that would have an ax to grind—there was $9,064 per capita in terms of assistance to senior citizens.

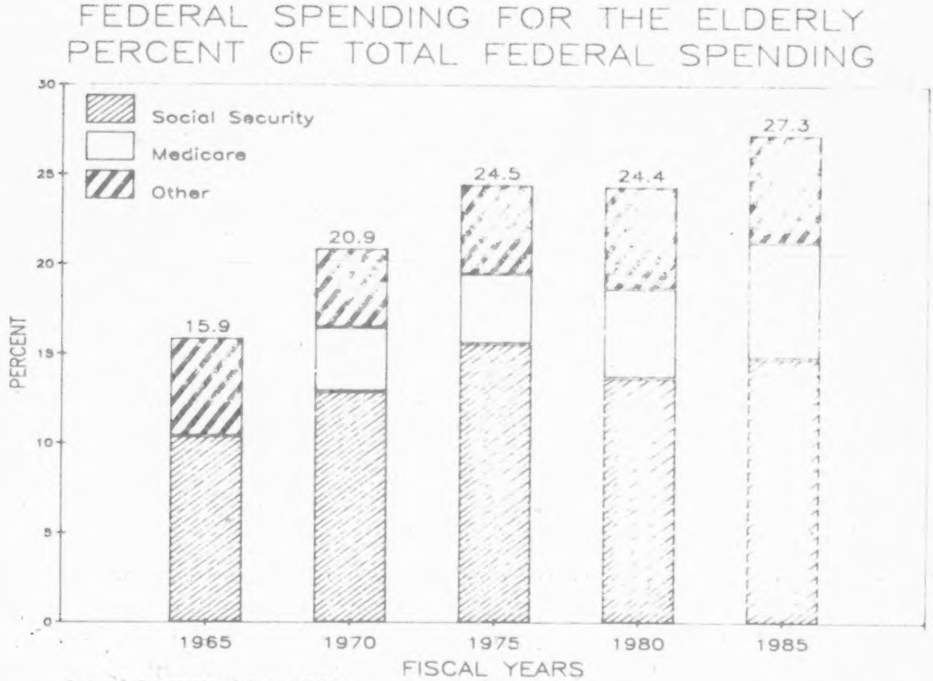


FEDERAL SPENDING FOR THE ELDERLY
PER CAPITA AGE 65 OR OLDER
(1985 DOLLARS)

Source: Congressional Budget Office

Others who have said—and I do not say this to either agree with the notion that we have spent too much on defense, or agree with the notion that we haven't spent enough on defense—that in the past 6 or 7 years, assistance to senior citizens has suffered as we have attempted to spend more on defense. I think that would show up in terms of the percentage of our budget that we spend on defense versus the percent that we spend on senior citizens. If one had to go down at the expense of the other, it would seem to the Senator from New Mexico that as defense went up as a percent of the budget, you would find spending for senior citizens going down.

Quite to the contrary; Federal spending for the elderly, as a percent of total Federal spending, is depicted on chart 3. You will note that in the year 1980, 24.4 percent of the national budget was for elderly assistance. And you will find in 1985 that as a percent of the budget, they are 27.3 percent for the elderly programs.



Source: Congressional Budget Office

I only give the committee this—and those who are representatives of the senior citizen community out here who might be concerned—as evidence that your Congress and those representing you collectively—not Pete Domenici, or the Budget Committee, or this committee, but collectively—we have not cut back on senior citizen aid and assistance because we think anything else is more important, nor have the senior citizens on a per capita basis gone down in assistance over these years. Rather, it has gone up.

I have concluded, in observing all this, that America has very, very few successful social programs that are totally the result of the Federal Government's policies, but one that is clearly working is the American Government's program to help senior citizens. I believe every indication is that there is less poverty among seniors than there was 25 years ago; I believe that even in the last decade, there is less poverty among senior citizens than there is the population at large. I think those are dramatic indications that we have had some degree of success in this particular area.

Mr. Chairman, I too want to join Senator Chiles in commending you for the hearings, for focusing on keeping this thrust going, doing the very best we can for the senior citizens and not letting any process—budget, fiscal or otherwise—stop this momentum that we have of a primary social concern for our elders evidenced by putting the money where our rhetoric is and succeeding to some extent.

Thank you very much.

[The prepared statement of Senator Domenici follows:]

STATEMENT

SENATOR PETE V. DOMENICI

SENATE COMMITTEE ON AGING

MARCH 13, 1987

MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS HEARING TO EXAMINE THE EFFECTS OF THE FY 1988 BUDGET ON THE ELDERLY.

THE FEDERAL BUDGET HAS AN ENORMOUS IMPACT ON THE ELDERLY EVERY DAY OF THEIR LIVES. WE NEED TO BE REMINDED OFTEN OF OUR SPECIAL RESPONSIBILITY TO ASSURE THEM ADEQUATE INCOME, DECENT HEALTH CARE, AND PEACE OF MIND THAT THE BENEFITS WILL CONTINUE.

LET'S REMEMBER THAT WE CAN'T ASSESS THE IMPACT OF THE FY 1988 BUDGET ON THE ELDERLY OR ANYBODY. WE DON'T HAVE A BUDGET YET. THE BUDGET COMMITTEES WILL BEGIN TO PREPARE ONE NEXT WEEK.

ALL WE HAVE TO ASSESS ARE THE ADMINISTRATION'S BUDGET PROPOSALS. WE CAN TALK ABOUT THEM OR EVEN SCORN THEM. BUT CONGRESS NEVER ADOPTS THE PRESIDENT'S BUDGET IN TOTAL, AND WE WON'T THIS YEAR. SO LET'S NOT DWELL ON WHAT MIGHT BE, LET'S FOCUS ON WHAT IS.

THE FEDERAL BUDGET HAS BEEN VERY GENEROUS TO THE ELDERLY OVER THE PAST TWO DECADES. THAT IS A RECORD THAT CONGRESS AND THE AMERICAN PEOPLE CAN BE PROUD OF. NOT EVERYBODY REALIZES THE STRENGTH OF THAT RECORD, OR THEY MIGHT DISCOUNT MY CLAIM BECAUSE I WAS THE BUDGET COMMITTEE CHAIRMAN FOR THE PAST SIX YEARS.

I ANTICIPATED THAT AND ASKED THE CONGRESSIONAL BUDGET OFFICE (CBO) TO ANALYZE HOW THE ELDERLY HAVE FARED IN THE FEDERAL BUDGET OVER THE PAST TWO DECADES. THE CBO DATA SHOW A RELIABLE PICTURE OF THE INCREASING RESOURCES DEVOTED TO THE ELDERLY. I WOULD LIKE TO HAVE THE STUDY PUT INTO THE RECORD.

MR. CHAIRMAN, I WANT TO POINT OUT THREE FACTS THAT THE CBO STUDY MAKES VERY CLEAR.

THE FIRST CHART SHOWS THAT REAL FEDERAL SPENDING FOR THE ELDERLY HAS GROWN FROM $63 BILLION IN 1965 TO $259 BILLION IN 1985. THESE FIGURES ARE IN CONSTANT 1985 DOLLARS.

THE SECOND CHART SHOWS THAT PER CAPITA SPENDING HAS INCREASED GREATLY OVER THE SAME PERIOD. I POINT THIS OUT TO SHOW THAT SPENDING HAS INCREASED NOT ONLY BECAUSE THERE ARE MORE ELDERLY AMERICANS, BUT BECAUSE WE ARE MORE GENEROUS PER PERSON.

THE THIRD CHART SHOWS THAT THE SHARE OF THE FEDERAL BUDGET DEVOTED TO THE ELDERLY HAS INCREASED ALSO. THIS DEBUNKS THE MYTH THAT RESTORING AMERICA'S DEFENSES AT THE EXPENSE OF THE ELDERLY.

MR. CHAIRMAN, I AM NOT TAKING CREDIT OR BLAME FOR THESE NUMBERS. THE NUMBERS ARE AGGREGATES AND AVERAGES. THEY DON'T REPRESENT EVERY INDIVIDUAL CASE. THERE ARE MANY PROBLEMS OUT THERE THAT

MUST STILL BE ADDRESSED. THAT'S WHY WE HAVE COMMITTEES LIKE THIS AND HEARINGS LIKE THE ONE TODAY.

THESE ARE JUST THE FACTS, AS REPORTED BY THE CBO. BUT IT IS A VERY FAVORABLE RECORD OF BUDGETARY ACHIEVEMENT FOR THE ELDERLY, IN THE AGGREGATE.

I WOULD ALSO LIKE TO POINT OUT THAT THE BUDGET PROCESS ITSELF IS NOTHING FOR OLDER AMERICANS TO FEAR. CONGRESS HAS DONE MANY POSITIVE THINGS THROUGH THE BUDGET FOR THE ELDERLY.

LOOK AT LAST YEAR'S RECONCILIATION BILL. CONGRESS USED IT TO STRIKE AN OUT OF DATE LAW THAT WOULD HAVE AUTOMATICALLY FROZEN THE SOCIAL SECURITY COLA THIS PAST JANUARY. WE EXEMPTED ALL OF THE FEDERAL RETIREMENT COLAS FROM GRAMM-RUDMAN IN THE SAME BILL.

CONGRESS DECIDED TO LIMIT THE INCREASE IN THE MEDICARE DEDUCTIBLE TO $520 THIS YEAR AS PART OF THE BUDGET RESOLUTION. THAT SAVES THE ELDERLY $52 EVERY TIME THEY ENTER THE HOSPITAL.

THE RECONCILIATION BILL ALSO CONTAINED PROVISIONS TO IMPROVE THE QUALITY OF CARE UNDER THE MEDICARE PROGRAM, ITEMS THAT CONGRESS MAY NOT HAVE CONSIDERED WITHOUT THE RECONCILIATION BILL.

TO SUM UP, MR. CHAIRMAN, AMERICA'S SENIOR CITIZENS HAVE RECEIVED FAIR AND GENEROUS TREATMENT IN THE FEDERAL BUDGET, AS THE CBO STUDY DOCUMENTS. IN FACT, THE BUDGET PROCESS ITSELF HAS BEEN A VEHICLE FOR MANY FAVORABLE PROGRAM CHANGES FOR THE ELDERLY. THAT'S A RECORD WE CAN ALL BE PROUD OF.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Rudolph G. Penner
Director

February 17, 1987

The Honorable Pete V. Domenici
Ranking Minority Member
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Senator:

This letter responds to your request of December 16, 1986, for information on federal spending for the elderly under the principal programs benefiting them.

The enclosed table provides the data you requested. The table reports total federal outlays benefiting the elderly under the principal federal benefit programs for the years 1965, 1971, 1975, 1980, and 1985. Figures for all years other than 1965 were compiled by the Office of Management and Budget (OMB) and are reported in the 1986 Statistical Abstract of the United States, a publication of the Bureau of the Census. Data for those years are available separately for each of a dozen different programs or groups of programs, as well as for the set of all such programs taken together. Based on conversations with staff of the OMB, it appears that they have not prepared comparable figures for 1965. Therefore, for that year, total spending for the elderly under principal programs is reported, based on a nongovernmental source. Outlays under the Social Security program, which we were able to obtain, accounted for roughly two-thirds of the estimated total expenditures, however.

As you requested, total spending benefiting the elderly, as well as the program-by-program figures, are reported in several different forms: in billions of current dollars; in billions of constant 1985 dollars; in constant dollars per elderly person; as a percent of the gross national product; as a percent of total federal outlays; and as a percent of total federal outlays, except for defense and net interest payments.

As you noted in your letter, there are many problems in preparing this sort of data in a manner that is comparable both across programs and over time. Definitions of the elderly differ among programs, the quality of the data varies both over time and across programs, and there is no assurance that precisely the same techniques were applied by the many different people who compiled this information over the years. Nonetheless, these data probably provide a reasonably reliable picture of the increasing resources devoted to the elderly by the federal government during the past two decades.

Martin D. Levine of the Congressional Budget Office's Human Resources and Community Development Division, who prepared this information, has provided Michael Carozza with a magnetic disc containing the underlying data.

I hope you find this information to be useful. Please call me if you have any further questions, or have Mr. Carozza call Marty Levine at x62659.

With best wishes,

Sincerely,

Rudy Penner

Rudolph G. Penner
Director

Enclosure

cc: The Honorable Lawton Chiles
Chairman

TABLE 1. ESTIMATED FEDERAL SPENDING FOR THE ELDERLY UNDER SELECTED PROGRAMS: FISCAL YEARS 1965-1985

	1965	1971	1975	1980	1985
		In Billions of Current Dollars			
Social Security	12.3	27.1	51.8	81.2	140.4
Railroad Retirement	a/	1.7	2.8	3.6	4.7
Federal Civilian Retirement	a/	2.3	5.5	7.8	13.7
Military Retirement	a/	0.7	1.1	1.8	4.3
Benefits for Coal Miners b/	a/	0.1	0.2	1.3	1.5
Supplementary Security Income	a/	1.4c/	1.8	2.3	3.2
Veterans Pensions d/	a/	0.9	1.5	3.3	5.4
Medicare	a/	7.5	12.8	29.3	61.4
Medicaid	a/	1.9	2.6	4.7	8.5
Food Stamps e/	a/	0.2	1.0	0.5	0.6
Housing Assistance	a/	0.2	0.4	2.3	4.5f/
Other g/	a/	n.a.	n.a.	6.1	10.3
Total	18.8	44.0	81.3	144.2	258.6
		In Billions of Constant 1985 Dollars			
Social Security	40.9	69.7	101.0	107.5	140.4
Railroad Retirement	a/	4.4	5.5	4.8	4.7
Federal Civilian Retirement	a/	5.9	10.7	10.3	13.7
Military Retirement	a/	1.8	2.1	2.4	4.3
Benefits for Coal Miners b/	a/	0.3	0.4	1.7	1.5
Supplementary Security Income	a/	3.6c/	3.5	3.0	3.2
Veterans Pensions d/	a/	2.3	2.9	4.4	5.4
Medicare	a/	19.3	25.0	38.8	61.4
Medicaid	a/	4.9	5.1	6.2	8.5
Food Stamps e/	a/	0.5	1.9	0.7	0.6
Housing Assistance	a/	0.5	0.8	3.0	4.5f/
Other g/	a/	n.a.	n.a.	8.1	10.3
Total	62.6	113.1	158.5	191.0	258.6

(continued)

TABLE 1. (Continued)

	1965	1971	1975	1980	1985
		Per Person Age 65 or Older, in Constant 1985 Dollars			
Social Security	2,219	3,389	4,450	4,182	4,921
Railroad Retirement	a/	213	241	185	165
Federal Civilian Retirement	a/	288	473	402	480
Military Retirement	a/	88	95	93	151
Benefits for Coal Miners b/	a/	13	17	67	53
Supplementary Security Income	a/	175c/	155	118	112
Veterans Pensions d/	a/	113	129	170	189
Medicare	a/	938	1,100	1,509	2,152
Medicaid	a/	238	223	242	298
Food Stamps e/	a/	25	86	26	21
Housing Assistance	a/	25	34	118	158f/
Other g/	a/	n.a.	n.a.	314	361
Total	3,392	5,502	6,985	7,427	9,064
		As a Percent of GNP			
Social Security	1.83	2.56	3.40	3.04	3.57
Railroad Retirement	a/	0.16	0.18	0.13	0.12
Federal Civilian Retirement	a/	0.22	0.36	0.29	0.35
Military Retirement	a/	0.07	0.07	0.07	0.11
Benefits for Coal Miners b/	a/	0.01	0.01	0.05	0.04
Supplementary Security Income	a/	0.13c/	0.12	0.09	0.08
Veterans Pensions d/	a/	0.09	0.10	0.12	0.14
Medicare	a/	0.71	0.84	1.10	1.56
Medicaid	a/	0.18	0.17	0.18	0.22
Food Stamps e/	a/	0.02	0.07	0.02	0.02
Housing Assistance	a/	0.02	0.03	0.09	0.11f/
Other g/	a/	n.a.	n.a.	0.23	0.26
Total	2.79	4.16	5.34	5.41	6.57

(continued)

TABLE 1. (Continued)

	1965	1971	1975	1980	1985
	As a Percent of Total Federal Spending				
Social Security	10.4	12.9	15.6	13.7	14.8
Railroad Retirement	a/	0.8	0.8	0.6	0.5
Federal Civilian Retirement	a/	1.1	1.7	1.3	1.4
Military Retirement	a/	0.3	0.3	0.3	0.5
Benefits for Coal Miners b/	a/	h/	0.1	0.2	0.2
Supplementary Security Income	a/	0.7c/	0.5	0.4	0.3
Veterans Pensions d/	a/	0.4	0.5	0.6	0.6
Medicare	a/	3.6	3.9	5.0	6.5
Medicaid	a/	0.9	0.8	0.8	0.9
Food Stamps e/	a/	0.1	0.3	0.1	0.1
Housing Assistance	a/	0.1	0.1	0.4	0.5f/
Other g/	a/	n.a.	n.a.	1.0	1.1
Total	15.9	20.9	24.5	24.4	27.3
	As a Percent of Federal Spending, Except Defense and Net Interest				
Social Security	20.8	23.3	23.3	20.1	24.9
Railroad Retirement	a/	1.5	1.3	0.9	0.8
Federal Civilian Retirement	a/	2.0	2.5	1.9	2.4
Military Retirement	a/	0.6	0.5	0.4	0.8
Benefits for Coal Miners b/	a/	0.1	0.1	0.3	0.3
Supplementary Security Income	a/	1.2c/	0.8	0.6	0.6
Veterans Pensions d/	a/	0.8	0.7	0.8	1.0
Medicare	a/	6.4	5.8	7.2	10.9
Medicaid	a/	1.6	1.2	1.2	1.5
Food Stamps e/	a/	0.2	0.4	0.1	0.1
Housing Assistance	a/	0.2	0.2	0.6	0.8f/
Other g/	a/	n.a.	n.a.	1.5	1.8
Total	31.9	37.8	36.5	35.7	45.8

(continued)

SOURCES: Figures for 1971-1985 from 1986 Statistical Abstract of the United States; totals for 1965 from R. Clark and J. Menefee, "Federal Expenditures for the Elderly: Past and Future," The Gerontologist, April 1981; Social Security figures for 1965 were derived from 1965 Annual Statistical Supplement of the Social Security Bulletin and Fiscal Year 1987 Historical Tables of the Budget of the U.S. Government.

NOTES: Reported spending includes only federal outlays directed toward the elderly—people 65 years of age and older. Figures do not include federal outlays benefiting younger people or spending by state and local governments.

Details may not sum to totals because of rounding.

n.a. = not available.

a. Estimated total spending for the elderly in 1965 was taken from a source that did not report spending separately by program. Only Social Security spending could be estimated separately.

b. Prior to 1980, represents benefits for miners' widows only.

c. Represents grants to states to aid the aged, blind, and disabled.

d. Includes other veterans' compensation for the aged beginning in 1980.

e. Includes nutrition assistance to Puerto Rico.

f. Adjusted to eliminate outlays resulting from changing the financing procedures for public housing.

g. Includes, among other items, Administration on Aging programs, National Institute on Aging spending, housing loans for the elderly, and energy assistance.

h. Less than 0.05 percent.

The **Chairman**. Thank you very much, Senator Domenici.

I want to put something in perspective that Senator Durenberger touched on a little bit earlier today. He mentioned, Dr. Roper, that the increase in Medicare would go from $71.-something billion to $73.-something billion this year. Is that correct, under your proposal?

Dr. **Roper**. Yes, sir. That's essentially correct. It depends on how you——

The **Chairman**. All right. That's an increase of, what, about 2 percent?

Dr. **Roper**. Yes, sir.

The **Chairman**. And what's been the increase in hospital costs?

Dr. **Roper**. The estimate that we have is 4.5 percent.

The **Chairman**. That's 4.5 percent?

Dr. **Roper**. For 1988, yes, sir.

The **Chairman**. And what's been the increase in prescription drug costs?

Dr. **Roper**. I don't have that figure. I would be glad to supply it for you.

[The information to be supplied follows:]

The Bureau of Labor Statistics collects data on prices to prepare the Consumer Price Index. The price of prescription drugs is one of the data elements collected. During the period 1981-86, prescription drug prices increased an average of 10.6 percent per year or a total of 62 percent over the 5-year period. The data are not projected for future years, thus there is no information on estimated prescription drug price increases for 1988.

The Health Care Financing Administration collects data to prepare the annual "National Health Expenditure Report". Our data do not break out prescription drugs as a separate item. However, we do include drugs in a broader category which we categorize as "drugs and medical sundries". Prescription drugs are approximately 60 percent of this category. We estimate the increase in expenditures for this broader category in 1988 at 9.9 percent.

The **Chairman**. Would it be something in the neighborhood of 10 percent?

Dr. **Roper**. It may well be, sir.

The **Chairman**. And over 50 percent over the past 5 years?

Dr. **Roper**. It may well be.

The **Chairman**. You think you agree, but you're not sure?

Dr. **Roper**. I just don't have that figure, but it has increased, certainly.

The **Chairman**. And the percentage of increase in doctors' costs?

Dr. **Roper**. It's been increasing roughly 12 percent a year.

The **Chairman**. Twelve percent?

Dr. **Roper**. Yes, sir.

The **Chairman**. So in all of these items, they are much greater than the 2-percent increase in Medicare costs?

Dr. **Roper**. Certainly.

The **Chairman**. And will there be more people covered by Medicare this coming year?

Dr. **Roper**. Yes, sir.

The **Chairman**. How many more?

Dr. **Roper**. 300,000.

The **Chairman**. What percentage?

Dr. **Roper**. That's roughly 1 percent more.

The CHAIRMAN. Roughly 1 percent, so increases in costs are going to go up about 2 percent; there are going to be 1 percent more people that will divide up those costs, and the hospital costs and the drug costs and the doctor costs have all gone up a great deal more than 2 percent, have they not?

Dr. ROPER. And that's why we need very much to operate these programs more efficiently, as our proposals would do.

The CHAIRMAN. And your proposals would operate it more efficiently, you state, without having adequate research or sampling to demonstrate it? Isn't that true?

Dr. ROPER. We believe we've got adequate basis for these.

The CHAIRMAN. Well, I think that's doubtful.

But finally, one point. All this money comes out of the trust funds that we're talking about.

Dr. ROPER. No, sir; Part A, the hospital part of Medicare is trust fund dollars.

The CHAIRMAN. All right. And Part B is what?

Dr. ROPER. Part B, 25 percent is premium income from beneficiaries; 75 percent, general revenue of the Government.

The CHAIRMAN. All right. So there is general revenue involved there, but what proportion of them are out of the trust fund, or out-of-pocket costs by the——

Dr. ROPER. If you're lumping together Medicare and Medicaid, about half the $100 billion is trust fund dollars. The other half is divided between premium income and general revenue.

The CHAIRMAN. About half of it is out of the trust fund, which is a separate case, and about 25 percent of the other half is out of the elderly's pocket?

Dr. ROPER. Of Medicare Part B, yes, sir.

The CHAIRMAN. And so this will be cut, if you had your way, if the President's budget has its way. And I don't suppose you look at the other portions of the budget, do you, in the other departments?

Dr. ROPER. Not with any great detail, sir.

The CHAIRMAN. Well, I'll just tell you that the President recommends about an 8-percent increase in defense and about a 9-percent increase in foreign aid, just to put it into perspective. In other words, the savings come from the elderly, and the increases in these other parts of the budget.

Well, I thank you very much, Doctor, for your testimony.

I will be submitting additional questions for you to respond in writing.

Dr. ROPER. I'd be pleased to do that.

[The questions and the answers thereto follow:]

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

March 27, 1987

The Honorable William L. Roper
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 316 G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for appearing before the Senate Special Committee on Aging on March 13 and answering questions regarding the impact of the Administration's proposed budget for fiscal year 1988 on Federal agencies providing services to older Americans. Your testimony was helpful and we appreciated having the benefit of your views.

During the course of the hearing, Administration witnesses indicated that they would be willing to answer additional questions that Committee members did not have the opportunity to pose. Keeping this offer in mind, we request that you answer the following questions:

1. With the Administration's proposal to reduce the Medicare budget by $5.1 billion, how can you assure that beneficiary services would not be reduced? Please describe specifically how these cuts would affect out-of-pocket expenditures for beneficiaries.

2. You propose to increase Part B premiums for new Medicare beneficiaries to 35 percent of program costs. Instead of paying $22.30 per month, new beneficiaries would have to pay $31.20 per month. Why should Congress discriminate against new beneficiaries by charging them more than current beneficiaries? Will this create another "notch" group?

3. Suppose the Administration's catastrophic health plan is adopted by Congress and the premium is further increased by $5 or $6 in 1988.

   a. Are you concerned that new beneficiaries may not elect to buy into Part B because it will become too expensive?

   b. Do you have any studies which indicate that this will not be the case? If so, please provide any and all supporting documentation.

   c. If people do not buy into Part B, what effect is that going to have on the financing of the Administration's catastrophic plan?

4. About 20 percent of seniors cannot afford to purchase Medigap insurance, yet they do not qualify for Medicaid. Does it concern the Administration that with additional increases in premiums, many people will go with even less medical attention? How can we cope with this problem?

5. You are proposing to index the Part B deductible to the Medical Economic Index. Last year, medical care costs overall rose 7.7 percent, about 7 times as fast as the consumer price index. Since Social Security COLAs are tied to the CPI, how can we expect beneficiaries to be able to keep pace with these ever-increasing out-of-pocket health care expenditures?

6. Medicare mental health benefits have not changed since the program was established in 1965. Would you support legislation to adjust these benefits to reflect current needs and costs? Would you support legislation which extends mental health coverage to include reimbursement for non-physician practitioners, such as psychologists, as eligible for direct reimbursement? If not, please provide your rationale for this position.

7. In light of the tremendous costs faced by older persons who are severely mentally disabled or who are alcohol and/or drug abusers, why was mental health care not included in the catastrophic care plan that was endorsed by the Administration?

8. What do you perceive the impact of a Medicaid cap to be on services, such as mental health care, that are not currently directly reimbursed? What will be the impact on nursing home care? Will eligible beneficiaries be denied care when funding is exhausted in a particular year? Does the Administration have any evidence to show that cuts will not endanger quality? If so, please provide any and all supporting documentation.

9. Does the Administration's proposal for a 30-day turn-around time for clean claims mean that reimbursements will be made on clean claims in less than 30 days or will you hold reimbursements until day 30? If the claim is not clean, will this fact be conveyed to the beneficiary or provider immediately, or would the intermediary wait 30 days to let them know that further information is required or that the claim has been denied?

10. Delays may also lead physicians to refuse assignment for those doctors who believe it is far easier and more economical for them to collect directly from the beneficiary. Will your proposal harm our efforts to encourage doctors to accept assignment, particularly those with a high Medciare patient case mix?

11. The Administration's fiscal year 1988 budget proposes an expansion of the privatization of the Medicare program; you also propose the elimination of restrictions on premiums and profits for small private health plans. What specific steps are you taking towards guaranteeing quality of care beneficiaries under such plans?

12. You propose to save $10 million by placing radiologists, anesthesiologists and pathologists (RAPs) under the hospital DRG.

a. Will this system change the physician's relationship to the beneficiary from one of advocacy to one in which the physician is going to be in a position of having to limit access to services?

b. If the admitting physician, for example, has prescribed an X-ray for the patient, would the patient then be assured of receiving such a service, or would the hospital perhaps decide against this order?

c. How can you guarantee quality of care to the beneficiaries under such a system?

d. How will the RAPs be reimbursed under the DRG system?

e. How can we be assured that only unnecessary services are being deferred if the radiologist, for example, is under some kind of pressure to reduce overall services?

f. Would going forward with this proposal prejudice the administration's subsequent proposals with respect to a new reimbursement method for all physicians?

13. You propose to reduce payment for both direct and indirect medical education. How will such a reduction will effect beneficiaries?

14. The Congressional Budget Office estimates that administrative implementation of the Medicare catastrophic coverage would cost about $60 million in fiscal year 1988 under S. 210 and S. 592. Does HCFA's fiscal year 1988 Medicare contractor budget include any funds for this purpose?

15. Medicare finances 45 percent of all health care for older Americans, yet the program spends less than $5 million dollars each year on training physicians in geriatric medicine. Should HCFA play a greater role in efforts to train doctors and other health professionals in geriatrics? What specifically could HCFA do in this area?

16. Late last year, the President signed Public Law 99-660, an omnibus health bill which included an Alzheimer's disease research program. One goal of the legislation was to make sure that the affected agencies cooperated in developing a research agenda in this area. The exact language with respect to HCFA is: "In preparing and revising the plan...the Administrator of HCFA shall consult with the Chairman of the Council and the heads of agencies within the Department." Have you been following this charge and participated in developing research plans for this program? If so, please provide any and all supporting materials which document your Department's activity in this area.

17. HCFA received $1.2 million through the Labor/HHS Appropriations Committee for three respite care demonstrations for fiscal year 1987, and $40 million over three years in last year's Reconcilation legislation for demonstrations. Please describe the status of these projects and supply all supporting documentation.

18. Although several recent budget analyses have shown that profit margins for some hospitals were as high as 14 to 15 percent, proposals to significantly limit the update factor for PPS rates to between 1.5 percent and 2 percent may cause particular problems for rural hospitals.

a. How would such proposals affect rural hospitals, which are not prospering under PPS?

b. Can you assure us that rural hospitals, which are particularly vital to the communities they serve, will not be forced to close if this proposal is implemented?

c. If not, are you developing any measures to protect these vital rural health facilities?

19. We understand that the Administration is proposing to repeal legislation passed last year which would reimburse physicians' assistants under Medicare. What is the rationale for this proposal in light of the fact the CBO has said that the proposal would expose the Medicare program to no significant additional cost. Furthermore, a report done by the Congressional Office of Technology Assessment stated that "evidence indicates that nurse practitioners, physicians' assistants, and certified nurse midwives have positive infulences on quality of health care and access to services, and that they could increase productivity and save costs."

a. Can you explain the Administration's rationale for this proposal?

b. How much are you assuming that not reimbursing physicians' assistants, specifically, will save?

20. What do your latest estimates tell us about when the Part A Trust Fund will go into a deficit status, and what are we going to have to do to prevent such a situation? Is it correct to assume that the cost savings proposals you suggest for this year will not be enough to correct this situation?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by April 21, 1987. Therefore, we request that you relay your answers to the above questions prior to that date.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

John Melcher
Chairman

John Heinz
Ranking Minority Member

Questions for the Record
Senate Special Aging Committee Hearing on
FY 1988 Budget, April 13, 1987

1. Q. With the Administration's proposal to reduce the Medicare budget by $5.1 billion, how can you assure that beneficiary services would not be reduced? Please describe specifically how these cuts would affect out-of-pocket expenditures for beneficiaries.

   A. In FY 1988, 96 percent of proposed savings will come from changes in payments to providers and costs borne by third parties. Only 4 percent of the savings will be borne by beneficiaries. The increased income generated from the Medicare trust fund and help preserve current benefits.

   The following proposals would result in increased beneficiary costs:

   o Part B Premium Increase -- New enrollees would pay a premium equal to 35 percent of program costs ($31.20 in 1988). For current beneficiaries, the premium would continue to be set at 25 percent of program costs every year ($22.30 in 1988).

   o Part B Deductible -- The deductible would be increased by the Medicare Economic Index each year beginning in 1988. The deductible is currently $75 and would rise to $77 in 1988.

   In addition, beneficiaries would pay more due to delayed Medicare eligibility; repeal of program expansions in the Omnibus Budget Reconciliation Act, such as occupational therapy; and our proposal to require that all state and local government employees contribute to Medicare. These premium and deductible increases would be moderated by our physician proposals which would lower total part B costs, resulting in lower premium and coinsurance amounts.

   In addition, our legislative proposals include a catastrophic proposal that would increase the Medicare part B premium by a small amount, approximately $6.00 in 1988, to cover the catastrophic costs of covered services that exceed $2,000 in beneficiary out-of-pocket expenses per year.

2. Q. You propose to increase part B premiums for new Medicare beneficiaries to 35 percent of program costs. Instead of paying $22.30 per month, new beneficiaries would have to pay $31.20 per month. Why should

Congress discriminate against new beneficiaries by charging them more than current beneficiaries? Will this create another "notch" group?

A. Congress initially set the part B premium at 50 percent of program costs. Over time, this proportion has eroded to less than 25 percent. Congress is currently requiring a 25 percent minimum. The Administration's proposal seeks to restore the balance in funding of part B between premiums and general revenues. We propose an increase to 35 percent for new beneficiaries in order to phase the change in over time while avoiding impact on current beneficiaries who have developed retirement budgets around the existing premium structure.

3. Q. Suppose the Administration's catastrophic health plan is adopted by Congress and the premium is further increased by $5 or $6 in 1988.

   a. Are you concerned that new beneficiaries may not elect to buy into Part B because it will become too expensive?

   b. Do you have any studies which indicate that this will not be the case? If so, please provide any and all supporting documentation.

   c. If people do not buy into Part B, what effect is that going to have on the financing of the Administration's catastrophic plan?

A. Under the Administration's proposal the catastrophic premium will be approximately $6 in 1988. We believe that this premium is a very modest one that should not be a financial burden to the substantial majority of beneficiaries. Further, many of the lower income beneficiaries are also entitled to Medicaid, and the States pay the monthly Part B premium for most of these individuals.

Almost two-thirds of Medicare beneficiaries have purchased Medigap policies. These policies are more expensive than the Administration's catastrophic premium, and we believe that the large number of beneficiaries purchasing them demonstrates that beneficiaries will have no problem with the $6 premium.

Our proposal relates premium costs to catastrophic program costs. There won't be any cost to the Medicare trust funds. If costs per enrollee are higher than expected, then the premium will increase.

4. Q. About 20 percent of seniors cannot afford to purchase Medigap insurance, yet they do not qualify for Medicaid. Does it concern the Administration that with additional increases in premiums, many people will go with even less medical attention? How can we cope with this problem?

A. In our judgment, an access problem does not currently exist for those few beneficiaries without Medigap insurance. This is due, in part, to the myriad of Federal, State and locally sponsored health care programs for the poor and near poor. In particular, the medically needy provisions of the Medicaid program cover seniors who have incurred large medical bills, although they may not qualify for categorical assistance. Consequently, increases in beneficiary cost sharing should not lessen this present protection. We recognize that every proposal to address catastrophic illness coverage has some inherent inequities. We believe that a modest premium that will retain budget neutrality over time if the fairest, least costly way to address the problem.

5. Q. You are proposing to index the part B deductible to the Medical Economic Index. Last year, medical care costs overall rose 7.7 percent, about 7 times as fast as the consumer price index. Since Social Security COLAs are tied to the CPI, how can we expect beneficiaries to be able to keep pace with these ever-increasing out-of-pocket health care expenditures?

A. Our budget seeks to reduce the costs of health care for the elderly by providing incentives for providers and physicians to slow the growth in the cost of their services. To the extent our reforms are effective in reducing excessive costs -- for example, the fees of cataract surgeons -- the Medicare Economic Index will increase more in line with other areas of the economy.

Beneficiaries can reduce their out-of-pocket costs through several "informed consumer" activities. For example, beneficiaries can choose physicians who accept assignment or participate in the Medicare program. Beneficiaries can also join HMOs and have their out-of-pocket costs reduced as a result of the efficiencies of managed care.

6. Q. Medicare mental health benefits have not changed since the program was established in 1965. Would you support legislation to adjust these benefits to reflect current needs and costs? Would you support legislation which extends mental health coverage to include reimbursement for non-physician practitioners, such as psychologists, as eligible for direct reimbursement? If not, please provide your rationale for this position.

A. The Medicare mental health benefit was originally limited consistent with the Medicare program's focus on providing acute, short-term care to improve a beneficiary's health status. Currently 80 percent of the beneficiaries using the part B benefit incur charges well below the existing limit. Medicare benefits are not intended to provide long-term or chronic maintenance therapy, and the mental health limits were designed to assure only the provision a short-term intensive medical care. Because the Medicare population is predominantly elderly or disabled, physician management of different types of health care is important. Thus, there is no need to expand the benefit or the number of providers, such as non-physicians, who would be eligible for direct reimbursement.

Medicare beneficiaries can now enroll in prepaid health care plans which often provide additional benefits, including mental health benefits, at little or no additional cost. We believe that the capitation approach, in the long run, will be the best option for providing benefits in a cost-effective manner. However, we cannot support expanding Medicare benefits at this time when we are trying to preserve existing benefits and reduce the Federal deficit.

7. Q. In light of the tremendous costs faced by older persons who are severely mentally disabled or who are alcohol and or drug abusers, why was mental health care not included in the catastrophic care plan that was endorsed by the administration?

A. In structuring the catastrophic proposal for Medicare, we remained consistent with the overall benefit policy structure that exists in the current statute. In the Administration's catastrophic proposal, coverage of physician treatment of hospitalized patients is the same for medical and psychiatric disorders. In addition, coverage of care in general acute hospitals is the same. We do not see the catastrophic proposal as an appropriate vehicle for costly additions to existing coverage. Although the Medicare law does not specifically address treatment of alcoholism or drug abuse, coverage of such services is available within the existing benefit package and in accordance with Medicare coverage rules. Medicare not only covers the costs of alcohol or drug detoxification and rehabilitation treatment programs, it also covers the cost of services required for the treatment of medical conditions related to alcoholism or drug abuse. A variety of options for the treatment of mental disorders is also available, within certain limitations, under existing Medicare law.

8. Q. What do you perceive the impact of a Medicaid cap to be on services, such as mental health care, that are not currently directly reimbursed? What will be the impact on nursing home care? Will eligible beneficiaries be denied care when funding is exhausted in a particular year? Does the Administration have any evidence to show that cuts will not endanger quality? If so, please provide any and all supporting documentation.

A. Based upon our experience with reductions in Federal reimbursements to States for Medicaid in FYs 1982, 1983 and 1984 under the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), we are confident that States will meet the challenge of managing within the slower growth in Federal expenditures which we are now proposing. States were able to do more with less in large part because the cuts in Federal funding were accompanied by significant additional flexibility for States to experiment with ways Medicaid services are organized and delivered and the methods by which providers are paid. We believe that the States will make good use of the additional flexibility we are offering to produce additional savings which can be redirected to meet a variety of needs.

Our data for long term care institutions show that the Medicaid population increased modestly between 1975 and 1982, by about 1.7 percent per year. More recently, in FY 1982, the Medicaid institutional population declined by 7.8 percent. While the absolute numbers of aged Medicaid recipients continued to grow, the percentage of the elderly population in long term care institutions declined slightly from 4.6 percent in 1976 to 4.2 percent in 1982. We believe that these reductions are due, at least in part, to States taking advantage of increased administrative flexibility. For example, the States have been energetic in implementing home and community-based waiver programs which permit the elderly to be cared for in the home and community at a lower cost and greater recipient satisfaction than institution-based care.

We do not believe that eligible recipients will be denied care. States are responsible for assuring that certain basic services are available. In addition, a contingency fund would be available in FY 1988 for States which encounter unusual financial difficulties, despite aggressive efforts to contain costs.

We have no evidence that reductions in Federal Medicaid funding have adversely affected the quality of services. We will continue our quality assurance efforts to insure that quality standards are met.

9. Q. Does the Administration's proposal for a 30-day turnaround time for clean claims mean that reimbursements will be made on clean claims in less than 30 days or will you hold reimbursements until day 30? If the claim is not clean, will this fact be conveyed to the beneficiary, or would the intermediary wait 30 days to let them know that further information is required or that the claim has been denied?

A. Our budget proposal for FY 1988 anticipates that all clean claims will be paid between the 28th and 30th day after receipt.

When we receive claims that are not clean, we immediately notify the beneficiary or provider that the claim has been denied or that we need supplemental information.

10.Q. Delays may also lead physicians to refuse assignment for those doctors who believe it is far easier and more economical for them to collect directly from the beneficiary. Will your proposal harm our efforts to encourage doctors to accept assignment, particularly those with a high Medicare patient case mix?

A. Currently, over 70 percent of claims are paid under assignment. Our research shows that physicians accept assignment for a variety of reasons. There is no evidence that rapidity of payment is a factor in a physician's decision to accept Medicare payment as payment in full. Thus, we do not believe that our proposal will have a major effect on the decisions of physicians to accept assignment.

11.Q. The Administration's fiscal year 1988 budget proposes an expansion of the privatization of the Medicare program; you also propose the elimination of restrictions on premiums and profits for small health plans. What specific steps are you taking towards guaranteeing quality of care for beneficiaries under such plans?

A. We plan to have an independent quality assurance review system in place by June 1987 that will review the quality of care in all HMOs. Under our plan, either a peer review organization or other quality review contractor will review a sample of cases in each HMO to assess the quality of care. The contractor will review both inpatient and outpatient services. Action will be taken to correct problems when they are found.

12.Q. You propose to save $10 million by placing radiologists, anesthesiologists and pathologists (RAPS) under the hospital DRG.

a. Will this system change the physician's relationship to the beneficiary from one of advocacy to one in which the physician is going to be in a position of having to limit access to services?

b. If the admitting physician, for example, has prescribed an X-ray for the patient, would the patient then be assured of receiving such a service, or would the hospital perhaps decide against this order?

c. How can you guarantee quality of care to the beneficiaries under such a system?

d. How will RAPs be reimbursed under the DRG system?

e. How can we be assured that only unnecessary services are being deferred if the radiologist, for example, is under some kind of pressure to reduce overall services?

f. Would going forward with this proposal prejudice the Administration's subsequent proposals with respect to a new reimbursement method for all physicians?

A. Four of your questions are concerned with beneficiary access to quality care, which we believe will not be changed under our proposal. Tests are ordered by attending physicians who are outside the RAP payment system. Efficiencies will be achieved by education of attending physicians when their patterns of ordering services are outside practice norms established by their colleagues as adequate for high quality of care. However, attending physicians will not have a direct financial stake in ordering fewer services.

In addition, beneficiaries do not now choose their providers of RAP services. They generally rely on the recommendation of the admitting physician or hospital. We believe that the professionalism of both groups will assure that necessary services are provided and that quality is maintained. We will continue our external review of hospital inpatient services through peer review organizations to detect any problems of underservice or poor quality.

Your other concerns relate to the mechanics of our RAP proposal. We have not mad a final decision as to the method we will use to pay RAPs under our proposal.

There are two basic options:

One option would be to incorporate the payment for RAP services into the DRG rate and pay the hospital. This approach could entail changing most payment rules affecting physicians such as assignment and billing beneficiaries. In addition, numerous individual physicians and physician groups indicated deep concern about folding their payments into hospital payments.

A second option, which we believe may be preferable, is to make the RAP payments to physicians. We would be designing this payment system specifically for RAP services. For example, update factors could be tailored to reflect changes in RAP services rather than adopting or modifying the PPS market basket and update system. Hospitals and physicians could maintain independent relationships, and physicians could continue to balance-bill (that is, charge beneficiaries more than the Medicare-approved amount) on a limited basis. We intend that beneficiaries would have at least as much protection as under the MAAC (maximum allowable actual charge) limits.

Our proposal would not reduce necessary services. Rather, we intend to accomplish savings by encouraging more efficient delivery of services. We will continue to monitor to assure that services meet quality of care standards, a key consideration. Other goals are to provide incentives for physician efficiency; permit reasonable administration of the system; assure beneficiary access to services; and design a system that minimizes disruptive changes to existing physician billing and assignment options. We continue to oppose mandatory assignment.

The Medicare prospective payment system for hospitals now provides incentives for cost-efficient and quality care in the appropriate setting. A separate prospective payment for RAP services provided by physicians to hospital inpatients would extend parallel incentives to all RAP procedures performed during a hospital admission. Our proposal is in the final stage of review. A reformed payment system for RAP services based on an average prospective price will result in cost savings to Medicare; more appropriate treatment for the patient; and a more rational payment system.

13.Q. You propose to reduce payment for both direct and indirect medical education. How will such a reduction affect beneficiaries?

A. Medicare is only one payer of medical education costs. Our medical education proposals will reduce subsidies that were set too high and provide an unnecessary incentive for physician training at a time when a surplus of physicians exists. Our proposal to reduce unnecessary medical education payments is a prudent decision that will assure beneficiaries that we can meet our budget targets by controlling excessive costs in the health delivery system without reducing essential services.

14.Q. The Congressional Budget Office estimates that administrative implementation of the Medicare catastrophic coverage would cost about $60 million in fiscal year 1988 under S. 210 and S. 592. Does HCFA's fiscal year 1988 Medicare contractor budget include any funds for this purpose?

A. There is no money in the Medicare program management budget for the implementation of catastrophic coverage. The costs of administrative implementation of catastrophic coverage will be funded by the increased part B premium.

15.Q. Medicare finances 45 percent of all health care for older Americans, yet the program spends less than $5 million dollars each year on training physicians in geriatric medicine. Should HCFA plan a greater role in efforts to train doctors and other health professionals in geriatrics? What specifically could HCFA do in this area?

A. Medicare is not a training program; it is primarily an insurance program to protect against the costs of acute and sub-acute care. With limited resources available, it is important that Medicare continue to devote program funds to paying for services necessary to meet the basic health care needs of the elderly and the disabled.

16.Q. Late last year, the President signed Public Law 99-660, an omnibus health bill which included an Alzheimer's disease research program. One goal of the legislation was to make sure that the affected agencies cooperated in developing a research agenda in this area. The exact language with respect to HCFA is: "In preparing and revising the plan...the Administrator of HCFA shall consult with the Chairman of the Council and the heads of agencies within the Department." Have you been following this charge and participated in developing research plans for this program? If so, please provide any and all supporting materials which document your Department's activity in this area.

A. The Council members have been designated and the members representing HCFA, the National Institute on Aging, the National Institute of Mental Health, and the National Center for Health Services Research are in the process of collecting information on Alzheimer's disease that will be compiled for the required August research plan for Congress. We believe that Alzheimer's research is an important priority and that a coordinated plan will assure that the funding of targeted, high quality research studies is maximized.

17.Q. HCFA received $1.2 million through the Labor/HHS Appropriations Committee for three respite care demonstrations for fiscal year 1987, and $40 million over three years in last year's reconciliation legislation for demonstrations. Please describe the status of these projects and supply all supporting documentation.

A. We will implement the Congressional mandate for respite care demonstrations to explore a range of options for caring for victims of Alzheimer's disease patients in three phases. The first phase will involve a project to develop the demonstrations; this project will be awarded during FY 1987. The second phase will be the actual implementation of the demonstration sites and provision of services; this phase will begin in FY 1988. The final phase will be an independent evaluation of the demonstration sites.

Our projects will focus on addressing the criteria for determining who is eligible for services as an Alzheimer's victim to be maintained in their homes and in the community. It will also assess the cost and impact of supportive services, counseling and respite care for the family, as well as direct services to the Medicare Alzheimer's patient. We are working with relevant agencies, such as the Office of Human Development Services, within and outside of the Department of Health and Human Services, to develop our demonstration projects.

18.Q. Although several recent budget analyses have shown that profit margins for some hospitals were as high as 14 to 15 percent, proposals to significantly limit the update factor for PPS rates to between 1.5 percent and 2 percent may cause particular problems for rural hospitals.

a. How would such proposals affect rural hospitals, which are not prospering under PPS?

b. Can you assure us that the rural hospitals, which are particularly vital to the communities they serve, will not be forced to close if this proposal is implemented?

c. If not, are you developing any measures to protect these vital rural health facilities?

A. Although urban hospitals as a group have shown higher operating margins than rural hospitals, over 71 percent of rural hospitals had positive operating margins in the first year of PPS. Rural hospitals have shown tremendous gains in efficiency, as have urban hospitals. Moreover, we have every indication that the years after full implementation will be just as successful as the transition years.

We are in the process of implementing two new modifications that should improve Medicare PPS rates to rural hospitals. The first change involves the calculation of the PPS outlier payment rate. This will increase rural hospital aggregate payment. Also, the change from using hospital-weighted averages to case-weighted averages in calculating the payment rates should benefit rural hospitals significantly. Together these two changes will increase rural payments rates by about 6 percent in FY 1988. Other adjustments already in the system to assist rural hospitals include:

- o The swing-bed option which enables small rural hospitals to provide a skilled level of care to post-acute patients and receive the Medicaid payment rate for SNFs, thereby avoiding maintenance costs of idle capacity.
- o Sole community hospital (SCH) designation which permits rural hospitals to maintain the 75 percent hospital-specific/25 percent Federal PPS payment blend even after all other hospitals have moved to fully Federal rates. Also SCHs experiencing an uncontrollable decline in their patient volume greater than 5 percent are provided payment adjustments through their 1988 fiscal year.
- o Revisions in case-mix and patient volume criteria which ease qualification as a regional referral center. These rural hospitals can then receive the urban amount for the non-labor portion of their PPS payment rate.
- o Payment adjustments of 4 percent for rural hospitals experiencing a disproportionate share of at least 45 percent elderly and poor patients.

Many factors other than Medicare payments affect a hospital's financial stability, such as demographic change and individual hospital management practices. Thus we cannot predict whether or not hospitals will close. We emphasize, however, that the update we recommend will allow hospitals to maintain the current level of quality care now being delivered to Medicare beneficiaries.

19.Q. We understand that the Administration is proposing to repeal legislation passed last year which would reimburse physicians' assistants under Medicare. What is the rationale for this proposal in light of the fact that CBO has said that the proposal would expose the Medicare program to no significant additional cost. Furthermore, a report done by the Congressional Office of Technology Assessment stated that "evidence indicates that nurse practitioners, physicians' assistants, and certified nurse midwives have positive influences on quality of health care and access to services, and that they could increase productivity and save costs."

a. Can you explain the Administration's rationale for this proposal?

b. How much are you assuming that not reimbursing physicians' assistants, specifically, will save?

A. The current surplus of physicians speaks to the general availability of physician services. In addition, we have not seen evidence that beneficiaries are experiencing difficulty in obtaining necessary care. The physician assistant provision will likely result in additional, and perhaps duplicative, professional services being billed to Medicare because of the requirement that such care be supervised by a physician in order to qualify for Medicare payment.

We estimate repeal of this provision would save about $28 million over the next 5 years.

20.Q. What do your latest estimates tell us about when the part A Trust Fund will go into a deficit status, and what are we going to have to do to prevent such a situation? Is it correct to assume that the cost savings proposals you suggest for this year will not be enough to correct this situation?

A. The report of the Medicare Board of Trustees indicates that the present financing of the Hospital Insurance Trust Fund is sufficient to ensure the payment of benefits and maintain the fund until just after the turn of the century.

However, the 1987 report also calculates that making the Hospital Insurance Trust Fund solvent over the next 25 years would require a 13 percent reduction in Medicare expenditures or a 15 percent increase in contributions or some combination thereof. Our part A proposals would reduce the growth of Medicare expenditures by $3.5 billion in 1988 and increase revenue to the Health Insurance Trust Fund by $1.7 billion in 1988 and by $11.1 billion through 1992.

The CHAIRMAN. A statement by Senator Glenn and one by Senator Pressler will be made a part of the record at this point.

[The prepared statements of Senator Glenn and Senator Pressler follow:]

Senator
John Glenn
News Release

STATEMENT OF SENATOR JOHN GLENN

AT A HEARING OF THE SENATE SPECIAL COMMITTEE ON AGING

THE PROPOSED FISCAL YEAR 1988 BUDGET:
WHAT IT MEANS FOR OLDER AMERICANS

Friday, March 13, 1987 10:00 a.m.	Room 628 Dirksen Building Washington, D.C. 20510

Mr. Chairman, as you know, the Reagan Administration's Fiscal Year (FY) 1988 budget would significantly cut Medicare, Medicaid and other health and social services programs in order to reduce the federal budget deficit. Congress has rejected many of these proposed cuts in the past, and I am sure we will do so again.

Reducing the federal budget deficit must be at the very top of our agenda. It will require tough choices with regard to setting national priorities. However, I am convinced we can produce a budget that combines compassion with common sense, and I will continue to work to ensure adequate funding for programs which benefit our nation's elderly and low-income citizens.

Unlike the Administration, I do not believe that the way to reduce the deficit is by increasing out-of-pocket expenses for Medicare beneficiaries. Today, the Medicare program pays for less than one-half of older Americans' total medical bills. This means that many elderly citizens are already burdened by health care costs. I am opposed to the Administration's attempts to increase the Part B premium and deductible and to delay by one month initial eligibility for Medicare.

Medicaid, our federal-state program to provide health care for low-income Americans, serves less than 40 percent of those in need. It is the only program which finances long-term nursing home care, a growing need given the aging of our population. President Reagan's earlier budgets slashed federal Medicaid spending. This led to reimbursement and benefit restrictions, and exacerbated the growing national problem of uncompensated care for the medically indigent. The Administration's current proposal to cap Medicaid payments to the states would cause great hardships. As I have in the past, I will oppose the Medicaid cap, and I fully expect that it will be rejected by the Congress.

A top priority for me has always been our commitment as a nation to basic federally-funded biomedical research. We are on the verge of critical scientific breakthroughs in our knowledge of disease and in our understanding of the aging process. Therefore, I believe that the Administration's proposal to cut overall spending at the National Institutes of Health represents a penny-wise and pound-foolish approach to rationing our federal budget resources. I will continue to give high priority to federal funding for biomedical research, and I expect that Congress will once again reject the Administration's proposed cuts.

The Older Americans Act (OAA) provides many valuable programs for our nation's senior citizens including nutrition and social services, meaningful activities, and the opportunity for employment, all of which help enable older individuals to remain independent, contributing members of their communities. Congress has begun hearings on this year's reauthorization of the Older Americans Act. Given the increasing demands on the OAA programs -- due in part to our growing "old-old" population and the earlier discharge of Medicare patients from hospitals -- I am working to strengthen the Act, not to dilute it. Therefore, I am opposed to the Administration's plan to block grant the Older Americans Act programs and to reduce funding for research by 50 percent. It is unlikely that these proposals will be considered, much less accepted, by Congress.

The programs administered by the Social Security Administration (SSA) touch nearly every American, and it is important that we increase public respect and confidence in Social Security not decrease it. The SSA must maintain an organization in which the public has a high degree of confidence and with which it is willing to cooperate. What people think of the program derives in part from the type of personnel hired, the location of field offices, and the provision of friendly and dependable service to the public. Funding for the administrative portion of the Social Security budget has already been cut, since it is not exempt from the Gramm-Rudman budget-balancing law, as are Social Security benefits. In the past, Congress has rejected President Reagan's proposed personnel reductions and field office closings that would reduce the quality of service given to the public. As Chairman of the Governmental Affairs Committee, I will work to prevent the Administration's proposed reductions for FY 1988 which would require staff cuts of 4,000.

Today we will hear from members of the Reagan Administration with responsibility for administering the important programs I have mentioned -- Medicare, Medicaid, research at the National Institutes of Health, the Older Americans Act and Social Security. It will be interesting to hear their assessments of the impact of the Administration's budget proposals on the programs they administer. But I must admit, I do not believe that they will be able to give explanations which will convince me that these proposals would not weaken our commitment to Americans in the areas of income security, health and social services.

Mr. Chairman, I commend you for holding this hearing today. I look forward to hearing from the Administration witnesses, as well as from advocates for elderly and low-income Americans representing the American Association of Retired Persons (AARP) and the National Council of Senior Citizens (NCSC).

STATEMENT OF SENATOR LARRY PRESSLER
SENATE SPECIAL COMMITTEE ON AGING
"THE PROPOSED FISCAL YEAR 1988 BUDGET:
WHAT IT MEANS FOR OLDER AMERICANS
March 13, 1987

First, I would like to thank both sides of the Aging Committee staff for their excellent analysis of the Fiscal Year 1988 budget for programs affecting older Americans. Both reports will be very valuable tools for all Senators and their staff as we move forward in developing a Senate budget resolution and eventually a reconciliation bill.

I commend Chairman Melcher and Senator Heinz for holding this hearing on what the FY 88 budget proposal means for older Americans. Unfortunately, in this Senator's opinion, the proposed Fiscal Year 1988 budget means bad news for older Americans. It means higher out-of-pocket health care costs, less housing and energy assistance and lower chances for breakthroughs in research on Alzheimer's disease and other areas.

Deficit reduction must remain one of our top priorities. But not at the expense of senior citizens living on fixed incomes. Medicare beneficiaries have faced repeated increases in out-of-pocket costs in the past, and the Administration's proposal for Fiscal Year 1988 offers little hope of relief for our already hard-pressed senior citizens.

That being said, I want to thank the Administration representatives for coming before this committee today. You must feel as though you have walked into the lions den. While it is easy for us to sit up on the dias and chew up your budget proposal, it is in our best interest to work together and find ways to eliminate waste, encourage competition, yet ensure quality care and access to services.

There is one underlying fact which cannot be forgotten when speaking of deficit reduction in programs serving older Americans: the elderly population is growing at the fastest rate in history. Short term "bandaids" to restrict spending on older Americans programs will only lead to enormous problems and financial obligations in the future. For example, greater support for Alzheimer's Disease research now, will save billions of lives and taxpayer dollars in the long run. Spending now on health education and prevention programs, analogously, will save billions in health care costs down the road. I could go on and on.

I understand we do not have a blank check in caring for our elderly. But, there are ways we can save money without cutting back on services and benefits that already fall painfully short. And we must examine in excruciating detail every possible way to save while still meeting the needs of those who need us most. Thank you Mr. Chairman.

The CHAIRMAN. Our next witness is Dr. James Wyngaarden, the director of the National Institutes of Health, accompanied by Dr. T. Franklin Williams, director of the National Institute on Aging.

Please proceed, Dr. Wyngaarden.

STATEMENT OF JAMES B. WYNGAARDEN, DIRECTOR, NATIONAL INSTITUTES OF HEALTH, ACCOMPANIED BY T. FRANKLIN WILLIAMS, DIRECTOR, NATIONAL INSTITUTE ON AGING

Dr. WYNGAARDEN. Thank you, Mr. Chairman. We appreciate very much the opportunity of appearing before you and the committee this morning to discuss the impact of the President's fiscal year 1988 budget request on NIH programs affecting the elderly.

As you know, sir, NIH is the principal biomedical research agency of the Federal Government. We support biomedical and behavioral research in many institutions in this country and a few abroad, and conduct research also in our laboratories in Bethesda. We train promising young researchers and we promote the acquisition and distribution of medical knowledge.

Many of our institutes conduct research that can be immediately identified with problems of the aged population. It's a definitional problem; one could view, of course, the general work in heart disease and cancer as being highly relevant, but if we restrict ourselves to an analysis of just those projects that involve the problems of the elderly in a unique way, we have a budget of about $300 million in such research and training each year. The largest share of that is in the National Institute on Aging, which accounts for about 60 percent of the total.

The National Institute on Aging, consistent with its congressional charter, supports and conducts biomedical and behavioral research and training on the aging process and the common problems of older people, and this involves a wide range of topics that both continue to differentiate between normal aging and the disease states and conditions common to older people that are potentially preventable and reversible.

I'll hit only the highlights of some of our research programs. We deal with such important diseases and conditions as Alzheimer's disease; risks of falls; osteoporosis and osteoarthritis, which contribute to immobility and hip fractures; problems of urinary incontinence; better understanding of nutrition, the effects of exercise, and healthy behavior in maintaining health and functioning in later years.

There has been a great deal of very exciting progress in Alzheimer's disease in the last year or two. Very important to this progress was the realization some years ago that Alzheimer's disease was not just an inevitable result of aging, that it was a specific disease with specific pathological changes. There has been a suspicion that some genetic factors were involved, and in the past year—actually, just within recent months—scientists have discovered evidence for a specific gene on chromosome 21 that is termed an "Alzheimer's susceptibility gene." This has been found in four families in different countries with high familial rate of Alzheimer's disease. In addition, as you know, the pathology of Alzheimer's disease involves neurofibulatory tangles and plaques in which an amyloid protein is deposited. The gene that controls the synthesis of that amyloid is also on chromosome 21; we don't know at present if it's close to, or even identical with, the susceptibility gene. That's currently under study.

Those findings are of particular interest because it's been known for some time that chromosome 21 is the chromosome that controls Down's syndrome. And in older patients with Down's syndrome, there are pathological changes very much like those of Alzheimer's disease so that from the standpoint of scientific insight, these are very exciting findings.

In addition, Mr. Chairman, an abnormal protein has been discovered in the brain of Alzheimer's patients, and that protein, termed "A68," is also detectable in the spinal fluid of Alzheimer's patients. This may permit a more precise diagnostic test because it is not always easy to differentiate Alzheimer's disease from other forms of dementia.

In other areas of the NIH we have important studies underway on Parkinson's disease. In an experimental model of Parkinson's disease it's possible to ameliorate that condition by transplanting, in animals, cells from a young animal's brain into those of older ones, or indeed, to transfer cells from the adrenal gland into the brain of animals with experimental Parkinson's disease, with partial recovery. These findings provide some important new insights, as well.

There is a new initiative that the National Institute of Aging is planning to begin this fiscal year, perhaps as early as May of this year, in cooperation with the Alzheimer's Disease and Related Disorders Association. A multi-center clinical trial will be conducted on the efficacy of tetrahydroaminoacridine, or THA, a drug that has been found to be of benefit to a small number of Alzheimer's disease patients in improving their memory and improving their ability to cope with their self-care needs. This drug needs to be studied further to determine whether or not it is indeed efficacious in a more carefully controlled trial, what proportion of patients may be responsive, what their special characteristics may be, the degree of improvement, and the duration of improvement. All those topics will be part of this very important study that is soon to get under way.

There are important advances also in the stroke problem. The improvement in hypertension control of recent years and other factors such as reduced smoking and changes in dietary habits, have brought a remarkable reduction in cardiovascular death rates, and also in the incidence of stroke. Those, unfortunately, are less dramatic in the black population than in the white population, and we are conducting studies to understand why that is the case.

Systolic hypertension is a common problem of the elderly in which just the systolic blood pressure varies above normal, the diastolic being normal. That condition predisposes them to stroke and other forms of cardiovascular disease and multi-infarct dementia. We have a combined study between the National Heart, Lung, and Blood Institute and the National Institute on Aging that is evaluating the effects of better hypertension control on the incidence of complications from that condition.

Osteoporosis is an important problem that is continuing to receive attention in several of our institutes. At a recent consensus development conference, scientists in this field agreed that small doses of estrogen, combined with some increase in calcium intake, had an effect of delaying the onset of osteoporosis in patients who took that drug appropriately. That's a topic that is a special priority of the new National Institute of Arthritis and Musculoskeletal and Skin Diseases as well, and we have very good working relationships among these agencies of Government.

Osteoarthritis, a very common problem of elderly people, will receive additional attention in workshops sponsored jointly by the Arthritis and Aging Institutes. That's a condition which is sadly in need of new scientific insights, and we hope that some will develop from this conference.

Eye diseases are a common problem of the elderly, and there has been a great deal of progress there, Mr. Chairman, in recent years on such diseases as aging-related maculopathy, cataracts, and glaucoma.

Oral health continues to be a problem of the elderly, although the cavity problem is under very good control in the younger population. Other types of cavities are common in elderly patients, and periodontal disease is a common problem of the elderly, and that's a very high priority area of the Dental Institute.

Since Dr. Williams became director of the Aging Institute, he's placed a very strong emphasis on the training of physicians and scientists in geriatrics. Many of our medical schools do not have strong programs in geriatrics. There are a number of new programs mentioned in the testimony that have placed emphasis on the training of more individuals in that area.

I'd like to make a few comments about the budget, Mr. Chairman. As you know, the process of developing the President's budget is a lengthy one; it involves well over a half year of numerous proposals and allowances and appeals. The budget must reflect the priorities within the NIH, among our various institutes. These must then be fitted in with the priorities in the Public Health Service and the Department to conform in context with the overall requirements of the President's budget.

We have protected, in the 1988 budget, the programs on AIDS in particular, and Alzheimer's disease is also right up there as one of our very high priority programs that is protected in this budget. With regard to the 1988 budget proposal, the NIH budget request includes $5.5 billion in new budget authority. The Administration is also requesting the extended availability of $334 million in fiscal year 1987 funds to be moved into 1988 to provide an obligational authority of $5.869 billion, an amount equal to the revised 1987 budget.

Under that proposed budget the number of new and competing research grants in 1988 would be the same as in 1987. The number of centers supported, including those for Alzheimer's disease research, would be the same, although the funding would be decreased about $1.4 million to a new figure of $522 million. Support for career awards and training would be at about the 1987 level. The other NIH research mechanisms would be maintained at a level almost commensurate with comparable 1987 funding levels.

Under the President's budget, we can expect to see continuing advances in understanding the biological process of aging, and we will certainly continue our remarkable progress in Alzheimer's disease.

Mr. Chairman, this concludes my prepared statement. Both I and Dr. Williams would be happy to answer any questions that you may have.

[The prepared statement of Dr. Wyngaarden follows:]

STATEMENT BY

JAMES B. WYNGAARDEN
DIRECTOR

NATIONAL INSTITUTES OF HEALTH
PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

U. S. SENATE SPECIAL COMMITTEE ON AGING

MARCH 13, 1987

Mr. Chairman and members of the Committee, I am Dr. James B. Wyngaarden, Director of the National Institutes of Health (NIH). I am responding to your invitation to present testimony on the impact of the President's fiscal year 1988 budget request on NIH programs affecting the elderly.

The NIH is the principle biomedical research agency of the Federal Government. The NIH supports biomedical and behavioral research in this country and abroad, conducts research in its own laboratories, trains promising young researchers, and promotes the acquisition and distribution of medical knowledge. These research activities uncover new ways to prevent and ameliorate disease and disability, seek to lessen the enormous economic and human toll exacted from the Nation, and lead to better health care for all Americans.

The National Institute on Aging (NIA), consistent with its Congressional charter, supports and conducts biomedical and behavioral research and training on the aging process and the common problems of older people. NIA-supported investigators are studying a wide range of topics relevant to this mission. Among these topics is the continued effort to differentiate between normal aging and those disease states and conditions common to older people which are potentially preventable or reversible.

The NIA supports a broad spectrum of research and training aimed at easing or eliminating the physical, psychological and social problems that beset many older persons. Research efforts include studies on the etiology, diagnosis and treatment of Alzheimer's disease; factors such as risks of falls, osteoporosis and osteoarthritis which contribute in major ways to immobility and hip fractures; the common problem of urinary incontinence; and the development of better understanding of nutrition, exercise, and healthy behaviors in maintaining health and functioning in later years.

NIA Intramural research activities include its 29-year-old Baltimore Longitudinal Study of normal aging, a research program in dementia in the NIH Clinical Center in Bethesda, and four Established Populations for Epidemiological Studies of the Elderly. The Institute also supports 10 Congressionally-mandated Alzheimer's Disease Research Centers, six Alzheimer's disease case registry programs, and a number of cell culture and small animal resources for research scientists studying the aging process throughout the nation.

NIA research is complemented by the research of at least four other institutes at the NIH: the National Heart, Lung, and Blood Institute (NHLBI); the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS); the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); and the National Eye Institute (NEI). These institutes support research in such areas as Alzheimer disease, systolic hypertension, osteoporosis, osteoarthritis, glaucoma, and cataracts.

ALZHEIMER'S DISEASE

NIA-supported research has recently produced a number of important discoveries and advances, particularly in the efforts to understand and conquer Alzheimer's disease. In just the past few weeks scientists supported primarily by NIA, as well as other Institutes at NIH, have reported fundamental advances in understanding genetic origins of at least some instances of Alzheimer's disease and the genetic region responsible for producing one of the principal proteins in the brain lesions in this disease.

In four families, residing in several countries, in which Alzheimer's disease is highly and predictably inherited, these scientists have used modern molecular genetics techniques to determine that the genetic basis for their disease is contained in a small section of chromosome 21 - one of the 23 pairs of human chromosomes. In other important related advances, another NIA grantee has isolated and analyzed an abnormal protein, the "A68" protein, from the brains of Alzheimer's disease patients that appears to be specific for Alzheimer's disease. This protein may prove to be a biochemical indicator of the disease, since it can be detected in spinal fluid. The NIA is supporting further efforts to identify and genetically characterize afflicted families, bank cells derived from family members, isolate cellular DNA and coordinate Restriction Fragment Length Polymorphism linkage studies utilizing these DNA samples.

Virtually simultaneously, several groups of scientists have reported cloning the genetic area which controlls the production of the amyloid protein that is deposited in the lesions in the brains of Alzheimer's victims. NINCDS researchers have cloned a normal human gene involved in making this amyloid. The gene directs cells to manufacture a large protein involved in the formation of amyloid, the abnormal substance seen as patches of degenerating brain tissue in Alzheimer's patients, as well as in the brains of normal older adults. This finding represents an important clue in understanding the cause of Alzheimer's disease and provides the basis for further research that may one day lead to the prevention and treatment of this and other progressively deteriorating disorders. It appears that this gene is also located on human chromosome 21, the chromosome associated with Down's syndrome. Of additional interest is the finding that adult Down's patients have Alzheimer's disease-like plaques and tangles in their brains.

In addition to the research outlined above, NINCDS scientists interested in neurological dysfunctions affecting older people are using a synthetic drug called MPTP to gain new insights into the cause of Parkinson's disease and are exploring ways to cope with hearing loss through studies concerning the mechanisms by which sound is transmitted to the brain. Potentially important applications to Alzheimer's disease and Parkinson's disease may also emerge from current studies of neuronal implantation. NINCDS scientists have implanted cortical cells from young rats into the brains of aging rats enabling them to remember how to solve life threatening problems by methods they previously knew but have lost the ability to remember. This research may someday not only provide possible approaches for treating patients with Alzheimer's disease, but for reversing memory deficits that result from the normal processes of aging.

A new initiative which NIA plans to begin fiscal year, in cooperation with the Alzheimer's Disease and Related Disorders Association (ADRDA), is a multicenter clinical trial of the efficacy of tetrahydroaminoacridine (THA) as a potential drug to slow the progression of Alzheimer's disease and improve the level of functioning of Alzheimer's disease patients. The need for an adequate controlled clinical trial is based upon some positive and provocative data, published in 1986, that indicate considerable improvement in function in a small number of Azlheimer's victims treated with THA. This paper engendered predictable excitement and dictated the need for a careful investigation to determine (1) if THA is efficacious in Alzheimer's disease; (2) the proportion of patients, and their characteristics, that obtain a clinically meaningful improvement from THA; and (3) the degree of improvement that can be anticipated. The Food and Drug Administration is working closely with NIA in guiding the further evaluation of this drug, in order to assure as quick an answer as possible on its safety and efficacy.

STROKE

The NINCDS supports individual investigators and teams of scientists in stroke and positron emission tomography (PET) research centers. Studies that monitor populations of stroke patients over periods of years give scientists time perspective to evaluate long-term damage and treatment effectiveness. The result of the extracranial/intracranial bypass surgery study, which indicated that the surgery is of no therapeutic benefit, has prompted scientists to consider similar evaluations of other commonly used neurosurgical and vascular surgical procedures, such as endarterectomy - the surgical removal of the inner layer of an artery when thickened or occluded, as by inner plaques. Such research is important to the health and pocketbooks of older Americans. Research continues to build toward the goals of stroke prevention, recovery of brain function, and improved quality of life for those who suffer stroke, all important concerns as our population ages.

SYSTOLIC HYPERTENSION

It has been estimated that in the United States alone, more than three million persons over the age of 60 have isolated systolic hypertension (systolic blood pressure over 160 mm Hg, diastolic blood pressure under 90 mm Hg) on a single measurement, and approximately half of them have systolic blood pressure elevation on repeated examinations. These persons face an excess risk of stroke, other cardiovascular disease and death. Systolic hypertension may even play a part in the etiology of multi-infarct dementia. A study on Systolic Hypertension in the Elderly, co-sponsored by the NIA and the NHLBI, has been developed to look at this population with sustained isolated systolic hypertension (ISH). This study is a multicenter clinical trial designed to determine whether the long-term administration of antihypertensive therapy for the treatment of isolated systolic hypertension, in men and women over the age of 60, reduces the combined incidence of fatal and nonfatal stroke. In addition, the study will include an evaluation of the effect of long-term antihypertensive therapy on cardiovascular morbidity and mortality in older persons with ISH, possible adverse effects of chronic use of antihypertensive drug treatment in this population, and the effect of therapy on indices of quality of life.

OSTEOPOROSIS

Another important area of research supported by NIA concerns risk factors for hip fractures. Osteoporosis significantly increases the risk of hip fracture. Although there is general agreement that estrogen therapy will slow bone loss in post-menopausal women, there remain many unanswered questions, including the exact mechanism of action, the best method of administration, the risks of prolonged use (which may be influenced by the route of administration) and the effects in women who are many years post-menopausal.

Scientists at the NIA Gerontology Research Center in Baltimore have devised what may be highly effective and safe procedures for taking hormone medication such as estrogen. Administration of these drugs under the tongue may enhance the success of treating such conditions as osteoporosis, premenstrual syndrome, and hypopituitarism. Other routes for administration of hormone medications which these scientists have helped develop are transdermal patches and nasal sprays. Such methods may prove superior to conventional ways of taking such medication.

The new National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) has targeted osteoporosis for special research emphasis in many ways, including a recent Scientific Workshop on Osteoporosis co-sponsored with other NIH Institutes, a program announcement focusing on "Research on Bone Active Hormones and Cytokines," and a Request for Applications for Programs of Excellence of Research on Osteoporosis jointly issued by the NIA, NIAMS, and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). The Programs of Excellence will focus on basic mechanisms leading to abnormal bone metabolism, means for accurate assessment of quantity and quality of bone; epidemiology and determining risk factors, preventive measures for various age groups, and treatments to restore structurally competent bone to the skeleton. A new clinical trial beginning in FY 1987 will be co-sponsored by NIAMS, NIA, NIDDK, NHLBI, and the National Institute of Child Health and Human

Development (NICHD). This trial will investigate the effects of estrogen and progestin on a variety of outcomes, including lipoproteins, bone mass, and gallstone formation.

OSTEOARTHRITIS

Proceedings and recommendations have been recently published from a very successful scientific workshop co-sponsored by NIAMS and NIA on Etiopathogenesis of Osteoarthritis. Workshop participants included experts in epidemiology, anatomy and pathology, biochemistry, bioengineering, inflammation, and clinical medicine. More than 120 recommendations for research areas to be pursued emerged from the workshop. A program announcement is being prepared by the NIAMS and NIA to stimulate research on osteoarthritis in these targeted areas.

DISEASES OF THE EYE

Ocular disorders that are common in older adults and are actively being studied by the NEI include aging-related maculopathy, cataract, and glaucoma. Aging-related maculopathy selectively affects the macula, the small area of the retina that provides sharp central vision. It occurs primarily with aging, impairing to some degree the vision of millions of Americans over age 50. An NEI-supported clinical trial, the Macular Photocoagulation Study, provided the first conclusive evidence that the vast majority of cases of blindness resulting from this disease could be prevented or delayed significantly by timely laser treatment if the disease is recognized early.

The NEI devotes most of its funding in the cataract program to research aimed at developing means of preventing or slowing the development of cataract or of treating it nonsurgically. Investigations are currently under way employing molecular biological techniques to study the alteration of lens proteins and investigate the extent to which such alteration affects transparency. Previous studies have indicated that oxidation of protein and lipid components of the lens is related to the onset of senile cataract. Investigators are attempting to determine whether a prime factor leading to this oxidative damage is the ambient ultraviolet light radiation in sunlight. Attempts are also being made to prevent or arrest cataract in animal models using antioxidants. Various epidemiologic studies of cataract are under way to determine environmental, nutritional, and genetic factors that may be involved in cataract development.

Although glaucoma may occur at any time in life, the risk of developing glaucoma increases with age. Treatment for glaucoma, whether by drugs or surgery, is aimed either at diminishing aqueous humor production or at facilitating its outflow. In an attempt to improve the outcome of glaucoma surgery, the compound 5-fluorouracil, a chemical that inhibits cell proliferation, is being administerated postoperatively under the conjunctiva of the eye in a randomized clinical trial. Administration of this chemical has been shown to enhance the success of conventional glaucoma surgery in high-risk patients. The purpose of the trial is to define further the safety and efficacy of this treatment. Another NEI-supported clinical trial is comparing the safety and efficacy of argon laser trabeculoplasty with that of traditional medical treatment with topical drugs in newly diagnosed patients with primary open-angle glaucoma.

ORAL HEALTH

Improving the oral health of older people is the focus of a collaborative project between the NIA, the National Institute of Dental Research (NIDR) and the Veterans Administration. A research agenda has identified critical areas such as the relationships between oral health and nutritional status and chronic pain in older persons.

GERIATRIC TRAINING

In response to the 1984 Congressionally-mandated plan to improve and expand training in geriatrics and gerontology, the NIA has intensified its efforts to train investigators and educators in aging research. This is being accomplished through the design and implementation of a variety of new approaches to training and career development. The Geriatric Leadership Academic Award, the Complementary Training Award for Research on Aging, and the Co-Funded Institutional National Research Service Award were first made in FY 1985. Other approaches include summer institutes in geriatric research for medical students and post-doctoral trainees, Special Emphasis Research Career Awards, and a training component in the NIA Teaching Nursing Home Awards.

In addition, as authorized by Congress in the 1986 Omnibus Health Act (P.L. 99-660), NIA is this year initiating a Program for Leadership and Excellence in Alzheimer's Disease, which also includes a training component, and is developing an Alzheimer's Disease Information and Education Center to provide health professionals and the public with up-to-date information on all aspects of this disease.

INTERAGENCY COMMITTEE

The Interagency Committee on Research on Aging, chaired by the National Institute on Aging, NIH, provides a central focus for Federal research on aging. Its key functions include: identification of research needs as well as research interests that cut across Federal agencies and departments in order to promote appropriate collaboration and to avoid duplication of effort; sharing of proposed research strategies and anticipated projects; and exchange of information about existing research. Other interests of the Committee include looking into the feasibility of developing a computerized database of information on federally-supported research on aging and convening a group of agency representatives interested in activities to improve the quality of home care of older adults.

The process of development of the President's budget is a lengthy one, encompassing well over half a year and numerous clearances and adjustments. Priorities that emerge represent a series of choices and compromises. Each institute at NIH must, by the nature of the process, have its priorities compete with those of the other institutes, all within the context of the overall requirements of the President's budget. These NIH priorities then compete with those of other agencies within the Department. To the extent possible, NIH and the Department have emphasized research related to aging, and most particularly research on Alzheimer's disease.

With regard to the impact of the proposed FY 1988 budget, the NIH budget request includes $5,534 million in new budget authority. With the extended availability of $334 million in FY 1987 funds, the total obligational authority for 1988 would be $5,869 million, which is approximately equal to the level of the revised 1987 budget.

This budget, in addition to maintaining approximately the same number of research project grants at a constant level, would also permit the NIH to continue to fund the same number of center grants, including the Alzheimer's Disease Research Centers, but with a decrease in funding of $1.4 million from the 1987 level to a new figure of $522 million. Support for career awards and research training would be available at almost the same level as the 1987 revised budget, with the training program supporting approximately 10,867 trainees - almost the level recommended by the National Academy of Sciences. In the aggregate, the other NIH research mechanisms would be maintained at a level almost commensurate with comparable 1987 funding levels. Under the President's budget we can expect to see continued advances in understanding the biological basis of aging, and we will certainly continue our remarkable progress in Alzheimer's disease.

Mr. Chairman, this concludes my prepared statement. I will be glad to answer any questions you or the members of your Committee may have.

The CHAIRMAN. Doctor, you've had a rather outstanding career in medicine. The funds that you handle for research and the grant money, I understand from reading the President's budget, would defer some $329 million for this year's grants and hold them over to next year. Is that true?

Dr. WYNGAARDEN. Yes, sir, that is still part of the proposal. As you may know, we had begun to make some adjustments in the number and size of awards in early January following the President's budget message. We have, at the request of Congress and with the approval of OMB, stopped doing that as of March 3, so we are now proceeding during 1987 to make awards according to the original 1987 budget.

The CHAIRMAN. Where did that idea originate?

Dr. WYNGAARDEN. I'm told that it developed in conversations between OMB and the Department. We did not play any role in that ourselves.

The CHAIRMAN. Isn't it true, Doctor, that research delayed is a tragedy?

Dr. WYNGAARDEN. Yes. Each year we conduct, under the available funds, the highest priority research that we can identify. And there's always a good deal of research that we cannot support under any budget; that's always been the case.

The CHAIRMAN. To the extent that the dollars are appropriated, though, you've always found applicant grants—or applicants for grants—that indeed do meet all the requirements of prudent research? Isn't that true?

Dr. WYNGAARDEN. Yes. In the last few years we have funded between 35 and 38 percent of approved and recommended projects.

The CHAIRMAN. In other words for every three grant applications, you get to choose approximately one of those three as the best and most prudent?

Dr. WYNGAARDEN. Yes. That's been true for several years.

The CHAIRMAN. So there was a hiatus there, sometime in January until March 3rd, that you were holding up on awarding grants. I assume that since March 3rd that you will utilize the grant money for the full amount that was appropriated, then? Or will there be some that is still carried over, some funds still carried over?

Dr. WYNGAARDEN. No, sir. We were primarily reducing the size of the award by an additional 6 or 7 percent on average to stay within the proposed revision of the President's budget. We have now restored those funds to the original level that would have been possible under the appropriation, and as rapidly as possible we will forward to each grantee those funds that were withheld as a consequence of this proposal. We expect to have that accomplished within a month.

The CHAIRMAN. Are you still using the peer review process?

Dr. WYNGAARDEN. Oh, yes sir.

The CHAIRMAN. And in that process, isn't there often negotiation for a lesser amount?

Dr. WYNGAARDEN. Yes, at several levels, Mr. Chairman. The grant undergoes two levels of review. The first is a disciplinary review for scientific merit and technical feasibility. We have about 80 or 85 committees of volunteers from the scientific community that evaluate these grants and place priorities on them. They also look at the proposed budgets very carefully—these are scientists who understand what research costs, because they are doing similar kinds of research—and they make recommendations on the budgets. The grant is reviewed a second time at the level of a council of the funding institute, which looks at the work done by the study section but also considers policy issues and program balance and geographical issues and the like, and it then approves and also recommends a budget.

The grants management staffs of the funding institutes then negotiate that budget more carefully with the grantee, and sometimes they find that small savings can be made. In general, historically we have funded the new and competing awards at about 3 percent less than recommended figures, and the continuations at about 1 percent less. But the additional dollar negotiations that I referred to as a result of this proposal were on top of that.

The CHAIRMAN. Doctor, while I've got you here—it's an unusual opportunity—are you aware of the—this has nothing to do with the elderly—are you aware of the requirement for changing the policy for taking care of primates that are used in research at NIH and other institutions?

Dr. WYNGAARDEN. Yes, sir. We have had an animal welfare policy longer than we have had a human subject welfare policy. That welfare policy for animals has undergone repeated revisions. We have the fifth major revision of that policy in force at present, and with respect to the care of primates, it does define some new requirements for larger cages and other measures. Yes, sir, that's a very lively topic and we spend a great deal of time on that.

The CHAIRMAN. Well, the psychological well-being of primates is a term that means just that. We'll be wanting to review—not on this committee, but on another committee that I serve on—just what progress you've been making.

Dr. WYNGAARDEN. We're taking that term very seriously, and we are applying that in every way that we know how to do it.

The CHAIRMAN. Thank you very much, Dr. Wyngaarden and Dr. Williams. We commend you on your work, and I think a lot of us feel that some of the best dollars that are ever appropriated out of Congress go to NIH. Thank you very much.

Dr. WYNGAARDEN. Thank you, Senator Melcher. We thank you for your support.

The CHAIRMAN. I will be submitting written questions to you and Dr. Williams following this hearing.

[The questions and the answers thereto follow:]

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

March 31, 1987

James B. Wyngaarden, M.D.
Director
National Institutes of Health
Building 1, Room 124
9000 Rockville Pike
Bethesda, Maryland 20892

Dear Dr. Wyngaarden:

Thank you for appearing before the Senate Special Committee on Aging on March 13 and answering questions regarding the impact of the Administration's proposed budget for Fiscal Year 1988 on Federal agencies providing services to older Americans. Your testimony was helpful and we appreciated having the benefit of your views.

During the course of the hearing, Administration witnesses indicated that they would be willing to answer additional questions that Committee members did not have the opportunity to pose. Keeping this offer in mind, we request that you answer the following questions:

1. Late last year, the President signed into Public Law 99-660 an omnibus health bill which included an Alzheimer's disease research program. It is our hope that we can appropriate money for that program this year, as authorized by the legislation. In the meantime, with the assumption that Congress would fund this program, the agencies involved were to be proceeding with a plan for the research. Can you give us an update as to how the planning for research on Alzheimer's authorized by this new law is progressing? Please provide any and all documentation with regard to this issue.

2. The Administration's fiscal year 1988 budget proposes significant funding decreases for the National Institutes of Health (NIH).

   a. How would this reduction impact NIH research and training efforts? Please provide information about what specific areas of research related to aging will be affected.

James B. Wyngaarden, M.D.
March 31, 1987
Page 2

b. How can we prevent decreases in our commitment to biomedical research from having an adverse impact on attracting new researchers to the field of aging?

3. Although the Office of Management and Budget and others have rejected the budget proposal to defer research funding from fiscal year 1987 to fiscal year 1988, it is unclear whether the White House has withdrawn this proposal.

a. Does the President still support the deferral appropriations proposal that was included in his fiscal year 1988 budget proposal?

b. The deferral proposal is not now being implemented. If it was included in the final budget signed into law by the President, how would it affect ongoing research and training activities within the NIH?

C. How would the deferral proposal allow the NIH to take full advantage of present research opportunities in the aging field?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by April 21, 1987. Therefore, we request that you relay your answers to the above questions prior to that date.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

John Melcher
Chairman

John Heinz
Ranking Minority Member

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

March 31, 1987

T. Franklin Williams, M.D.
Director, National Institute on Aging
National Institutes of Health
Building 31, Room 2C02
9000 Rockville Pike
Bethesda, Maryland 20892

Dear Dr. Williams:

Thank you for appearing before the Senate Special Committee on Aging on March 13 and for providing assistance to Dr. Wyngaarden prior to and during the course of our hearing on the impact of the Administration's proposed budget for Fiscal Year 1988 on Federal agencies providing services to older Americans.

During the course of the hearing, Administration witnesses indicated that they would be willing to answer additional questions that Committee members did not have the opportunity to pose. Keeping this offer in mind, we request that you answer the following questions:

1. New discoveries about Alzheimer disease are being made at an extremely rapid pace. Two findings recently reported in the news include the possibility of THA as a drug for treatment of this devastating disease. What are your Institute's plans for maintaining, and perhaps even escalating, our march toward a final victory against Alzheimer disease?

2. Late last year, the President signed into Public Law 99-660 an omnibus health bill which included an Alzheimer disease research program. It is our hope that we can appropriate money for that program this year, as authorized by the legislation. In the meantime, with the assumption that Congress would fund this program, the agencies involved were to be proceeding with a plan for the research. Can you give us an update as to how the planning for research on Alzheimer disease, as authorized by this new law, is progressing? Please provide any and all documentation with regard to this issue.

3. The Administration's fiscal year 1988 budget proposes an $11 million funding decrease for the NIA.

   a. How would this reduction impact the NIA's research and training efforts? Please provide information about what specific areas of research would be affected.

   b. How can you prevent such a decrease from having an adverse impact on attracting new researchers to the field of aging?

4. Similar to the teenage suicide problem, the issue of elderly suicide is of increasing concern to health care professionals. Men over the age of 75 have the highest rate of suicide of all age groups.

   a. Is the NIA supporting research initiatives, perhaps in conjunction with NIMH, in this area?

   b. If not, can you explain why the NIH is not involved in this area?

   c. If so, could you please provide the Committee with information about the roots of this problem and how we might address it.

5. The Institute of Medicine (IoM) will soon publish a study on the need for geriatric leadership in the United States. We understand that among the study's recommendations is a suggestion that comprehensive geriatric research and training centers should be established. In your opinion, would such centers be a suitable vehicle for addressing the country's geriatric leadership needs? If not, why not?

6. Considering the anticipated doubling of the over age 85 population by the year 2020 and the implications this has for the nation's health care and support systems, especially those dealing with long-term care, what is your Institute doing to meet this rapidly approaching and increasing challenge?

7. Since 1984, the number of full time equivalent positions at the NIA has declined from 378 to 343 (in the President's fiscal year 1988 budget).

   a. How can the Institute maintain its productive research programs and still reduce the numbers of its FTEs?

b. In what specific areas will there be (and has there been) staff reductions in the last three years?

8. Although the Office of Management and Budget and others have rejected the budget proposal to defer research funding from fiscal year 1987 to fiscal year 1988, it is unclear whether the White House has withdrawn this proposal.

a. Does the President still support the appropriations deferral proposal that was included in his fiscal year 1988 budget proposal?

b. The deferral proposal is not now being implemented. If it was included in the final budget signed into law by the President, how would it affect ongoing research and training activities within the NIA?

C. How would the deferral proposal allow the NIA to take full advantage of present research opportunities in the aging field?

9. What areas of research have you identified that the NIA is not pursuing now, or pursuing only minimally, that might offer promise for improving the health and well-being of today's and tomorrow's aging population?

a. What is the NIA doing to examine the role of nutrition in the aging process and health of the elderly? Where are there shortcomings in NIA initiatives in this area, and what can we do to address these shortcomings?

b. What is the NIA doing on the issue of pharmaceuticals and the elderly? Where are there shortcomings in NIA initiatives in this area, and what can we do to address these shortcomings?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by April 21, 1987. Therefore, we request that you relay your answers to the above questions prior to that date.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

John Melcher
Chairman

John Heinz
Ranking Minority Member

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

National Institutes of Health
Bethesda, Maryland 20892
Building : 1
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JUN -1 PM 2:30

MAY 28 1987

The Honorable John Melcher
United States Senate
Washington, D.C. 20510

Dear Senator Melcher:

I am responding to your letter of March 31 addressed to me and to Dr. T. Franklin Williams, Director, National Institute on Aging (NIA). I have enclosed our response to additional questions you asked us for inclusion in the record of the March 13 hearing on the impact of the proposed FY 1988 budget on Federal agencies providing services to older Americans. We wish to thank you for your interest and hope that our answers to your questions will prove helpful.

Sincerely yours,

James B. Wyngaarden

James B. Wyngaarden, M.D.
Director

Enclosures

Question #1. New discoveries about Alzheimer's disease are being made at an extremely rapid pace. Two findings recently reported in the news include the possibility of THA as a drug for treatment of this devastating disease. What are your Institute's plans for maintaining, and perhaps even escalating, our march toward a final victory against Alzheimer's disease?

Answer. The National Institute on Aging (NIA) currently has under review a proposal for a multicenter clinical trial of tetrahydroaminoacridine (THA) in the treatment of Alzheimer's disease. The NIA will be able to initiate this clinical trial on THA with unusual rapidity due to the availability of the ten Alzheimer's Disease Research Centers (ADRCs) and their well-developed and characterized patient populations.

Since the publication of the paper by Dr. William Summers in the November 13, 1986, issue of The New England Journal of Medicine, the ADRCs, the NIA, the Food and Drug Administration, and the Alzheimer's Disease and Related Dementias Association have been working closely to develop and initiate a well controlled multicenter trial, pending successful scientific review, by June 1, 1987. This is an interval of less than 7 months, indicating that with the cooperation of the various groups and Agencies, the Federal Government can be responsive to the needs of the public. It is likely that further drugs for the treatment of Alzheimer's Disease will be developed and need the resources of the ADRCs. Strategies for responding to these future needs will be developed within the ADRC program.

As proposed, this multicenter clinical trial of THA will involve the coordinated efforts of 17 research centers and a total of 300 patients. Evidence of whether or not THA is effective, in a significant number of patients may be known within 1 year. If THA proves effective in this population of well defined Alzheimer's patients, and if it is simultaneously shown to be safe in animal studies, we are confident that all relevant organizations will expedite introducing the drug to the American market.

It must be remembered that should the efficacy and safety of THA be confirmed, this treatment would be a palliative approach since the underlying process of degeneration of cholinergic neurons is not altered by the anticholinesterase activity of THA. However, the possibility of an extension of normal and productive life of both the AD patient and his/her family makes THA potentially useful in the treatment of AD, should the study confirm its positive effects. The search for other treatments of AD needs to continue as a high national priority.

Other areas of expanded research opportunities on AD are:

o early identification of AD;

- further development of neuropsychological, biochemical, and imaging diagnostic instruments;
- cross-cultural epidemiologic studies, both domestic and international, to identify risk factors;
- genetic linkage and gene identification;
- pharmacologic therapeutic modalities;
- new therapeutic interventions such as transplants of nerve cell populations;
- support strategies for family members and caregivers.

Research initiatives have been and are being developed for each of these areas.

Question #2. Late last year, the President signed into law Public Law 99-660, an omnibus health bill which included an Alzheimer's disease research program. It is our hope that we can appropriate money for that program this year, as authorized by the legislation. In the meantime, with the assumption that Congress would fund this program, the agencies involved were to be proceeding with a plan for the research. Can you give us an update as to how the planning for research on Alzheimer's disease authorized by this new law is progressing? Please provide any and all documentation with regard to this issue.

Answer. P.L. 99-660 authorizes and encourages expanded research and research training related to Alzheimer's disease by a number of Federal agencies. Part D, Section 931 of P.L. 99-660 authorizes the Director, NIA, to make awards to distinguished senior investigators who have made significant contributions to biomedical research related to Alzheimer's disease and related dementias. The funds awarded may be used to support the recipient's research program and to train outstanding junior investigators to conduct research in such areas. The awards are renewable annually for a total of 7 years. The bill authorizes annual appropriations of $5 million for FY 1988-1991. To implement the intent of this part, the NIA is establishing a competitive award for "Leadership and Excellence in Alzheimer's Disease" (LEAD) which will include the following components:

- Salary support for the applicant (who must be a leading senior investigator in this field) and the secretarial/administrative staff necessary for the conduct of the award, with the option of partial support of a core facility of the awardee's research program, e.g. animal resources, data bases, clinical or pathology facilities; no more than 30 percent of the award may be used for this component.
- Salary and research development support for the further career development of one or more junior researchers who demonstrate exceptional promise to conduct research in the area of aging

and Alzheimer's disease and related dementias; no more than 30 percent of the award may be used for this component.

- Support of the research program(s) of the recipient senior investigator in the following ways: (a) extension of his/her currently funded research, (b) support or expansion of the research of the outstanding junior investigator(s) for no more than 3 years, (c) support of innovative, opportunistic, or high risk research on aging and Alzheimer's disease and related dementias as pilot studies for no more than 2 years per project.
- Administrative extension of one or more current NIA supported research grants to the awardee for the duration of this award.

The objectives of this program are to help strengthen the capabilities of established senior investigators who have, distinguished records in biomedical research on Alzheimer's disease, by providing up to 7 years of major funding support, thus allowing the recipients the time to devote to research and the development of outstanding junior biomedical investigators interested in working on Alzheimer's disease and the related dementias associated with aging. The NIA has already begun to take steps to implement the specific legislation. A draft of the Request for Application (RFA) has been developed and it is anticipated that awards will be made by July 1988. The number of awards will depend upon the number of meritorious applications and the funds available.

Part E, Section 941 of P.L. 99-660 authorizes research relevant to the appropriate services for individuals with Alzheimer's disease and related dementias to better understand how to take care of the great numbers of people who are presently afflicted with dementia. The specific mandate to the NIA is the preparation of a plan for research and its transmission to the Chairman of the Council on Alzheimer's Disease, within 6 months after the date of enactment of this Act. This plan is being prepared. Although NIA's specific responsibilities as designated in this bill center on an examination of epidemiological and diagnostic aspects of Alzheimer's disease, the Institute will continue to emphasize, in addition to the biomedical area, such behavioral science research topics as the focus of and burden of the care of Alzheimer's disease victims and encourage studies on the effects of social and physical environments on the manifestation of the disease, factors associated with caregiving burden, and the testing of interventions to help patients, families and formal care providers cope with and manage the disease and related sequalae. Annual revisions of the plan must be submitted to the Council. The bill authorizes annual appropriations of $2 million for FY 1988-1991.

Although the specific function in Part E, Section 941 is new, the Institute has been supporting research in this area as follows:

- These research areas are incorporated in the objectives of the 10 ADRCs, supported under Section 445 of P.L. 99-158, and of the 6 Alzheimer's Disease Patient Registries, authorized in P.L. 99-158, Section 12, Part G.

- A Program Announcement, "The Epidemiology of Alzheimer's Disease and Other Dementing Disorders of Older Age" was issued September 19, 1986, with the first round of applications received at the February 1, 1987, receipt date. A copy is attached.

- A Program Announcement, "The Diagnosis of Alzheimer's Disease" was issued April 3 with the cosponsorship of NINCDS and NIMH. A copy is attached.

- Two RFAs are being developed for issuance in FY 1988: Development of Biochemical Markers of Alzheimer's Disease; Validation of Imaging Technologies in Dementing Disorders of Aging.

- The NIA continues to support research related to family care-giving and appropriate services for Alzheimer's disease patients.

- The NIA, along with the NINCDS and NIMH, is holding an NIH Consensus Conference on the Differential Diagnosis of Dementing Diseases, July 6-8, 1987.

- Semiannual meetings of the directors of the 10 ADRCs are held to enhance cooperation and communication among the Centers. Similar meetings will be held by the directors of the Alzheimer's Disease Patient Registries.

- Under the auspices of the NIA Office of Alzheimer's Disease Research, an NIH Alzheimer's Disease Research Coordinating Committee has been organized to facilitate communication between operating staff of the relevant Federal agencies.

- The NIA has served as a resource to several State agencies interested in establishing statewide Alzheimer's disease patient registries.

- The NIA is cooperating with private foundations, such as the John French Foundation and the Alzheimer's Disease and Related Dementias Association, in developing and planning workshops, such as on Criteria for Diagnosis of Vascular Dementia and on Strategies for Home and Community Care of Alzheimer's Disease Patients and Their Families, as well as in developing the major clinical trial described above to determine the efficacy of tetrahydroaminoacridine in the treatment of Alzheimer's disease.

Other agencies, specifically the National Institute of Mental Health and the National Center for Health Services Research and Health Care Technology Assessment, are also authorized by P.L.

99-660 to expand their research on Alzheimer's disease. It is anticipated that these various efforts will be coordinated through the NIA Office of Alzheimer's Disease Research and brought to the attention of the Alzheimer's Disease Council, established by P.L. 99-660, through the Advisory Panel which was also established by this law.

Question #3. The Administration's Fiscal Year 1988 budget proposes significant funding decreases for the National Institutes of Health (NIH). (3a) How would this reduction impact NIH research and training efforts? Please provide information about what specific areas of research related to aging will be affected.

Answer. If, as you assume, Congress rejects the President's proposal to extend the availability of $334.4 million of FY 1987 appropriated funds, the FY 1988 President's budget request of $5,534.3 million would represent a decrease of $649.6 million or 10.5 percent from the FY 1987 appropriated level of $6,183.9 million. At that budget level, NIH would reduce the number of competing grants in FY 1988 to about 1,916 awards. All other funding mechanisms would remain at the currently proposed level. High priority research related to aging, such as Alzheimer's disease, molecular genetics, and osteoporosis would continue to be supported at approximately the current level; grant-supported research in lower priority areas would decline.

Question (3b). How can we prevent decreases in our commitment to biomedical research from having an adverse impact on attracting new researchers to the field of aging?

Answer. One must keep in mind that, under the FY 1988 President's Budget, both the FY 1987 estimate and the FY 1988 request for NIH will each support over 19,000 total research project grants. These are the highest numbers ever to be supported in the history of the NIH. Therefore, it should still be encouraging to enter a research career.

Question #4. Similar to the teenage suicide problem, the issue of elderly suicide is of increasing concern to health care professionals. Men over the age of 75 have the highest rate of suicide of all age groups. (4a) Is the NIA supporting research initiatives, perhaps in conjunction with NIMH, in this area? (4b) If not, can you explain why the NIH is not involved in this area? (4c) If so, could you please provide the Committee with information about the roots of this problem and how we might address it.

Answer. In 1984 suicide was the fourteenth leading cause of death for those aged 65 and over. Given the stigma attached to suicide as well as a set of definitional problems, this is probably an understatement of its extent.

The NIA is supporting two extramural studies that deal with suicide among older people. One demographic study is investigating causes of death within the older population. This study is utilizing data on multiple causes of death. The study is thus able to investigate the pattern of diseases such as cancer that may be associated with suicide. A recent discovery by the study is the rapidly increasing rates of suicide among black males over age 75. The second study is investigating at an aggregate level the relationship between such demographic, economic and benefit policy changes as the increased size of the older population, improved social security benefits, etc., and changes in the suicide rate.

A number of risk factors for suicide among older people has been proposed, including financial strain, social isolation, a low level of social integration, poor health including loss of functional ability and the existence of multiple chronic diseases, spousal bereavement or terminal illness, fear of the impact of costs of illness on surviving spouses, depression, hopelessness, loss of autonomy, and a tendency to direct anger inwards toward the self.

Several of these risk factors and their exact relationship to suicide among older people have not been well characterized, and there are important demographic and epidemiological gaps in our knowledge. Thus, for example, while the relationship between clinical depression — which increases with age, and which can have preventable and curable psychosocial and medical causes — and suicide has been quite well specified, the relationship between poor physical health — especially of a terminal nature — and suicide has been much less well characterized. Knowledge is scarcest where suicide rates are highest, e.g., among the oldest old males. A forthcoming joint program announcement by NIA and NIMH on the interrelations between psychological functioning and health should provide some useful information in this area. A new initiative in gender differences will also add to our knowledge of the sex imbalance.

Question #5. The Institute of Medicine (IOM) will soon publish a study on the need for geriatric leadership in the United States. We understand that among the study's recommendations is a suggestion that comprehensive geriatric research and training centers be established. In your opinion, would such centers be a suitable vehicle for addressing the country's geriatric leadership needs? If not, why not?

Answer. Such centers would, in my judgment, be very helpful. Experience with NIH research and training center programs in other specialties has shown that they are very effective in promoting the development of a field nationwide.

Question #6. Considering the anticipated doubling of the over age 85 population by the year 2020 and the implications this has for the nation's health care and support systems, especially those dealing with long-term care, what is the National Institute on Aging doing to meet this rapidly approaching and increasing challenge?

Answer. The oldest old have a very high rate of morbidity and disability, and are heavy users of care. Nationally, almost 25 percent were institutionalized in 1980, while of those living in the community between 40-45 percent need the help of another person in order to function in everyday life. Nonetheless, a substantial percentage of the oldest old living in the community are physically robust with few health problems and lead active lives. There also appears to be significant state by state differences in the ability of the 85+ to function independently. This suggests that if we are able to better understand the modifiable factors that lead to the differences between the robust and the physically dependent oldest old we could develop successful prevention programs. Epidemiological evidence is only now beginning to emerge that risk factors, once though not to operate past age 65, can be applied to older age groups.

Through interagency agreements with the National Center for Health Statistics a start has been made in developing demographic and epidemiological data for research on the oldest old. For example, NIA has funded the Longitudinal Study of Aging to follow-up the 1984 Health Interview Survey old-old respondents as well as a follow-up of the National Nursing Home Study. However, many vital gaps remain since national surveys that are crucial to developing a national prevention plan such as the National Health Interview Sample and the National Health and Examination Surveys do not adequately sample the very old, do not plan adequate longitudinal surveillance, and do not measure functioning adequately.

There are a number of complexities in predicting the current needs of this population. First, as already noted, because of the vital data gaps in national surveys and the lack of research projects analyzing available data we have a very inadequate picture of the needs of the current oldest old population. Second, there is very rapid change in the nature and size of the cohorts which survive into very old age. Future cohorts of the oldest old are likely to have different patterns of disease, social support, financial resources, and coping styles. Third, the methodology for making forecasts of active and disabled life expectancy and population needs is inadequate. The NIA is planning to fund three studies that will improve the forecasts of future levels of active and disabled life expectancy of the oldest old population, as well as the patterns of need that will be generated. Such studies would serve as the planning base for an integrated prevention program.

A major focus of NIA research is to prevent disease and deterioration, and to maintain health and functioning up to the end of life. Over the last several years there has been a major initiative on strategies for maintaining health and effective functioning in the middle and later years. This initiative has been stimulated by a general program announcement, first released in 1981 and by subsequent more specific announcements focused on health, behavior and aging; social environments influencing health and effective functioning; and the oldest old.

Future plans call for continuation and greater specification of the initiative on health and effective functioning to include concerns with cognitive functioning and aging, gender effects on health and longevity, the roles of exercise and sound nutrition, and the evaluation of social and behavioral interventions for reduction of age related risks and conditions.

Furthermore, an NIA plan for long-term care research has been developed to identify important research needing attention in this area. This NIA initiative will focus on biomedical, behavioral and social research and research training in several areas related to NIA's concern with medical and non-medical long-term care needs of aged persons with chronic illnesses and their families. Research solicited from existing program announcements reflecting the total range of grant mechanisms is currently emerging on topics such as:

- The epidemiology of caregiving for frail elders in the community
- Factors affecting the need for and use of long-term care services
- Social and behavioral aspects of different types of institutional care
- social and behavioral interventions for preventing falls, urinary incontinence, or cognitive decline in old age

Question #7. Since 1984, the number of full-time equivalent positions at the NIA has declined from 378 to 343 (in the President's Fiscal Year 1988 budget). (7a) How can the Institute maintain its productive research programs and still reduce the numbers of its FTEs?

Answer. As awareness of the problems of aging has grown among the biomedical specialties, we have seen increased research interest from diverse fields including nutrition, cardiovascular research, orthopedics, pharmacology, and many more. Many of the NIA extramural grant program administrators are therefore currently administering diverse research areas. The NIA intramural research program, like that of other NIH Institutes, is a labor intensive enterprise. In FY 1986, the intramural program was reorganized to promote increased scientific productivity and efficiency in operations, and to assure that the allocation of resources reflected NIA priorities. Collaborative relationships and outside means of support have been actively sought, and purchase of equipment to promote office automation has been expanded.

Question (7b). In what specific areas will there be (and has there been) staff reductions in the last three years?

Answer. In 1984, the NIA used slightly less than 380 full-time equivalent employees (FTEs) compared with a projected 339 in FY 1987. The effect of this decline has been distributed throughout the Institute. The number of FTEs in the intramural program has been reduced by about 10 percent. The extramural research program, which is responsible for program development, review, and administration, has also been reduced by about 10 percent. The number of FTEs in Institute-wide administrative activities — including the functions of policy formulation, administrative services, financial and personnel management, and coordination of the Institute's activities within the NIH and other Federal agencies, has declined by about 23 percent.

Question #8. Although the Office of Management and Budget and others have rejected the budget proposal to defer research funding from Fiscal Year 1987 to Fiscal Year 1988, it is unclear whether the White House has withdrawn this proposal. (8a) Does the President still support the deferral appropriations proposal that was included in his Fiscal Year 1988 budget proposal?

Answer. At present, the deferral is still contained in the President's FY 1988 budget proposal.

Question (8b). The deferral proposal is not now being implemented. If it was included in the final budget signed into law by the President, how would it affect ongoing research and training activities within the NIH?

Answer. If the deferred proposal is enacted by the Congress, only those projects scheduled to receive awards subsequent to congressional action would have their grants reduced.

Question (8c). How would the deferral proposal allow the NIH to take full advantage of present research opportunities in the aging field?

Answer. The deferral proposal would ensure a stable source of funds for biomedical research. This will allow continued support of high quality aging research in the fields which are ripest for development and exploitation.

Question #9. What areas of research have you identified that the NIA is not pursuing now, or pursuing only minimally, that might offer promise for improving the health and well-being of today's and tomorrow's aging population?

Answer. Research involving the genetic analysis of Alzheimer's disease is now ripe for exploitation because of the recent discoveries that both the gene for the B-amyloid protein found in amyloid plaques and a genetic defect predisposing individuals to Alzheimer's disease are located on chromosome 21. Increased support is needed for identification and collection of material for genetic analysis of Alzheimer's disease, and molecular genetic analysis of the DNA to identify genes, locate these genes on the chromosome, and characterize the regulation of expression of these genes.

Another opportunity in the area of Alzheimer's disease research is a study aimed at defining the rates and risk factors for dementia and central nervous system aging among persons of Japanese ancestry. The proposed study would be carried out in Hawaii and Japan, in collaboration with Japanese investigators, and would allow comparisons between rates of dementia among genetically similar persons living in the two nations. It would be desirable to extend this study eventually to other minorities in the Pacific Basin, and to develop other cross-cultural comparative studies of risk factors for dementia in other populations of the world. In this regard, plans are in progress to establish the headquarters of a new World Health Organization research program in aging in close association with the NIA. International epidemiologic studies of dementia are one of the highest priority areas of research for the new WHO program.

The use of techniques of recombinant DNA to study changes in gene structure and expression, and the identification of genes responsible for increased longevity of mutants are promising areas of research in aging. For example, it has now been demonstrated that messenger RNA from senescent cells in culture can be micro-injected into the nuclei of young cells to inhibit further replication of these cells. In related experiments, a protein called "statin" has been identified in nuclear membranes using monoclonal antibodies specific for senescent cell proteins. The protein is found only in non-replicating cells, and is found both in vivo and in cells in culture. The state of the science is ready for basic research on understanding the nature of aging. Techniques are available to probe genetic changes, to distinguish aging processes from disease, and to eliminate many sources of variation in future biomarker research.

Cell death is a poorly understood phenomenon. Cell death can be either programmed, as during development, or traumatic, due to anoxia or a variety of specific damaging agents. Cell death has been implicated in several diseases, e.g., Alzheimer's disease and Parkinson's disease, and could also be a contributing factor in functional decline of tissues and organs during senescence. The mechanisms by which cell death occurs needs to be elucidated in order to understand what interventions may be useful in retarding cell death in specific tissues. One of NIA's important contributions to this and related research efforts is to maintain cell banks of aging animal colonies for the use of investigators.

The importance of nutrition in the aging process, though long recognized, has been little studied. New studies indicate that many older people consume far less than recommended levels of such nutrients as calcium, zinc, or vitamins B6, D, and E; but the studies do not show whether these low intakes reflect real deficiencies or simply altered nutritional requirements with age. The NIA is focusing its efforts on three central issues: relationships between aging and nutritional requirements; mechanisms underlying nutritional effects on aging processes; and behavioral and social correlates of nutrition. A unique and cost-effective opportunity to learn how the diets of older persons are related to their health and risks for diseases would be through a supplement to the soon to be implemented third Health and Nutrition Examination

Survey of the National Center for Health Statistics, which will begin in FY 1988.

Falls and hip fractures are a major problem for older people. Though we have now learned that estrogen can reduce bone loss, especially from the spine, in women in the years immediately after menopause (Type I osteoporosis), we have yet to learn how to prevent the continuing bone loss, especially in the hip, in persons over 65 (Type II osteoporosis), which leads to the high rates of hip fractures in both men and women in advanced age. Results from the NIA falls program have reinforced our belief that falls — a major cause of hip fractures — are not an inevitable consequence of old age, but are caused by problems which are potentially treatable or preventable. Many older persons prone to falls have dramatically less strength in some leg muscles than persons of a similar age who do not fall. Many also have neurologic abnormalities. Further research should lead to understanding the causes of their neuromuscular problems and to practical ways of preventing falls.

There are several promising avenues of research in the area of behavioral and social research which have not been fully realized. Although progress has been made in two areas highlighted as Institute-wide initiatives in previous years, the oldest old and strategies for maintaining health and effective functioning, growth in these important areas requires continued support. NIA has also been supporting a small but growing number of research grants related to the need for and use of medical and nonmedical long-term care for chronically ill persons and their families. Additional efforts are needed here to address new aspects of the initiative outlined in an NIA Implementation Plan for Long-term Care Research for FY 1987 and Future Years.

Other promising research areas which have had inadequate attention in the past include research on cognitive functioning and aging, and the effects of gender on health and longevity. Especially neglected have been studies on special populations such as the oldest old, ethnic and minority populations, older people in rural settings, or behavioral and social research on persons with Alzheimer's disease and other dementias. Only recently have international research efforts been promoted to understand the similarities and differences in health, health care, and risk factors across population groups.

Question (9a). What is the NIA doing to examine the role of nutrition in the aging process and health of the elderly? Where are there shortcomings in NIA initiatives in this area, and what can we do to address these shortcomings?

Answer. The NIA supports research on the nutritional status and needs of the elderly. These studies have shown that many older persons consume far less than the recommended levels of several nutrients, such as vitamins B6, D, and E, as well as calcium and zinc. It is important to determine whether these low intakes reflect real deficiencies or simply altered nutritional requirements with age, since other NIA-supported studies have shown that increased intake by older persons of nutrients such as zinc may carry risks as well as benefits.

There has been a scarcity of good research proposals to sort out the risks and benefits of different intakes of various nutrients by older persons. This may be due to the complexities of the job. There are very many nutrients to consider, and the nutritional requirements of the elderly are affected by a variety of diseases, medications, and other factors. NIA believes the only adequate approach is to tackle the needs for each nutrient in detail, including the effect of chronic disease, interactions with other nutrients, and other factors. To this end, we have initiated a series of research planning conferences. Each will identify needs for research on a particular topic, as a basis for a subsequent NIA solicitation for research projects. These conferences will begin in FY 1987, and funding for the research solicitations will begin in FY 1988. Research issues to be addressed include optimal caloric intake and body weight, the role of B vitamins in preventing neurologic diseases of old age, effects of dietary calcium on bone density in older persons, and many others.

NIA has also collaborated with the National Center for Health Statistics (NCHS) in identifying important information which could be collected through the third Health and Nutrition Examination Survey (NHANES III). The NHANES III will be the first HANES survey to gather data on persons over the age of 74. This would provide a unique opportunity to learn how the diets of older people are related to their health and risks for diseases. Because the NHANES III budget is limited, additional support will be needed to address many critical questions about how dietary factors may help prevent diseases of old age. Depending upon availability of funds, the NIA will participate in a collaborative effort with the NCHS to implement data collection on dietary estimates and indicators of diseases in older persons in NHANES III.

Question (9b). What is the NIA doing on the issue of pharmaceuticals and the elderly? Where are there shortcomings in NIA initiatives in this area, and what can we do to address these shortcomings?

Answer. The NIA continues to support studies on the relationship of age to the effectiveness and side-effects of pharmaceuticals. For example, studies at Vanderbilt University have shown that the effects of diazepam (Valium) are prolonged in the elderly. This can cause oversedation leading to accidents such as falls, if dosage and frequency of medication are not adjusted. Researchers at the University of California at San Francisco have found that many older patients are more sensitive to several general anesthetics and analgesics used in surgery. Adjusting the dosages of these drugs could lessen the risks of surgery for older persons.

Despite NIA's efforts, there are still shortcomings in the extent of research focused on why some older persons are prone to specified adverse drug reactions, and why certain drugs are not as effective as we would like them to be in some older persons. A big problem is that most studies on drugs in older people have been on relatively healthy persons, but it is sick people who need medication. Diseases affect responses to drugs. Many older patients take several drugs for several diseases. It is a major research challenge to sort out the complex interactions among drugs and diseases that lead to adverse reactions and poor responses to treatment in older patients. This may be why so little has been done on this problem, and why some initiative from NIA could help. The NIA plans an initiative in FY 1988 for collaborative studies between geriatricians and pharmacologists to learn better means of improving options for drug treatment and preventing adverse drug reactions in older patients.

NIA has also tried to increase older persons' knowledge about prescription drugs. In particular, three NIA "Age Pages" on minor tranquilizers and drugs for heart disease and arthritis are being distributed extensively nationwide. NIA sponsored a conference in December 1986, and will sponsor another in May 1987, involving representatives of the pharmaceutical industry and focusing on adverse drug reactions. These should increase awareness among professionals about this problem, and have already identified important issues for this initiative.

PROGRAM ANNOUNCEMENT: THE EPIDEMIOLOGY OF ALZHEIMER DISEASE AND OTHER DEMENTING DISORDERS OF OLDER AGE

NATIONAL INSTITUTE ON AGING

BACKGROUND

The U.S. Congress, through the "Health Research Extension Act of 1985-P.L. 99-158" authorized the National Institute on Aging to "make a grant to develop a registry for the collection of epidemiological data about Alzheimer's disease and its incidence in the United States, to train personnel in the collection of such data, and for other matters respecting such disease." Applicants were required to have "expertise in the collection of epidemiological data about individuals with Alzheimer's disease and in the development of disease registries..."

To execute the intent of Congress, the NIA issued a Request for Applications for Cooperative Agreements for Alzheimer Disease Patient Registry (ADPR). This Program Announcement intends to complement and to extend the more narrowly defined and specific research initiated by the ADPR Request for Applications. The Program Announcement is designed to solicit limited focused investigations to address diagnostic criteria, screening instrument development and casefinding procedures, and methodological issues in population studies prior to launching large scale population based studies on the important substantive epidemiological questions. Epidemiological research is needed to complement other ongoing clinical and basic research sponsored by the NIA and other NIH components, including the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS), and the National Institute of Mental Health (NIMH).

RESEARCH GOALS AND SCOPE

Alzheimer disease and other dementing disorders of older age are common conditions in the U.S. population and the population of other developed countries. The U.S. population affected by Alzheimer disease has been variously estimated at 2 to 3 million cases. The imprecision and variability of the estimates of the incidence and prevalence of Alzheimer disease and other dementing disorders of older age stem from differences in diagnostic criteria, data collection methods and the underlying age structures in the populations studied. The need for more definitive epidemiologic research is underscored by this imprecision and variability.

Clear, operationally defined and reproducible diagnostic criteria are required for cases very early in the course as well as those with more advanced disease. The Work Group on the Diagnosis of Alzheimer Disease of the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association established a set of criteria for the clinical diagnosis of Alzheimer disease. These criteria may not be optimal for use in screening large populations as they were intended for clinical use and were not operationalized. Screening instruments with known reliability, sensitivity and specificity against the current state of the art diagnostic procedures for the dementias of older age are required.

will be published in the NIH Guide to Grants and Contracts, Vol. 15, No. 8, Sept. 19, 1986.

These instruments must be culturally, socio-economically, and educationally non-biased for use in cross-cultural and international studies. The screening instruments must not be affected by repeat administrations and must be easy to use in large-scale population studies.

The development, standardization and validation of diagnostic screening instruments against subsequent neuropathological diagnosis is also required. Diagnostic screening instruments must be distinguished from clinical screening instruments where all presumed cases are referred for more extensive diagnostic evaluations. In some population studies, it will not be possible to subject each presumed case of dementia to an extensive diagnostic workup, so that instruments for the prediction of the probable underlying cause or causes are needed.

The development of more refined, valid and reliable methods for reconstructing histories of demented subjects and for interviewing proxy informants is also needed.

Examples of specific substantive research questions of interest include:

Is Alzheimer disease a single entity reflecting a single etiology/exposure, clinical and neuropathological picture? Are the neuropathological findings the "final common pathway" reflecting multiple and diverse etiologies and varied clinical pictures?

What is the natural history of Alzheimer disease? Does it vary by age of onset? By any other inherited or acquired characteristics?

Does the age-specific incidence rate continue to rise with advancing age, even into very late life?

Does the sex ratio remain constant throughout the age span?

What is the impact of Alzheimer disease on life expectancy? How does it vary by age at onset?

What are the immediate, pathologically verified, causes of death in Alzheimer victims?

Are Alzheimer patients excessively vulnerable to or protected from any other diseases or conditions?

What are the precursors of Alzheimer disease and other dementing disorders of older age? As reviewed by Mortimer and Hutton, several risk factors for Alzheimer disease have been implicated in small studies or postulated in the research literature. Advancing age is the only clearly acknowledged risk factor. A genetic predisposition has been observed in some families. Other suggested risk factors include advanced parental age, selective vulnerability to exposure to aluminum, exposure to slow virus, immunologic defects, thyroid disease and head trauma. The condition appears to be more common in women than men and perhaps slightly more common in black women than white women. There appears to be an association between Down syndrome and Alzheimer disease suggesting a chromosomal defect. The impact of geographic, socio-economic, racial, ethnic, or cultural characteristics on the risk of developing Alzheimer disease are unknown. Intense investigation of non-affected people 90 years of age and older may prove to be a particularly fruitful approach to research about risk factors for Alzheimer disease and other dementing disorders of older age. See Mortimer and Hutton, "Epidemiology and Etiology of Alzheimer's Disease", in Senile Dementia of the Alzheimer Type, J.H. Hutton and A.D. Kenney (Editors), Alan R. Liss, Inc., New York, 1985 and E. M. Gruenberg, "Epidemiology of Senile Dementia" in Advances in Neurology, Vol. 19, B. S. Schoenberg (Editor), Raven Press, New York, 1978, for more detailed discussions of these questions.

The research questions are not limited to the list above. Applications which creatively and rigorously address any area of the epidemiology of Alzheimer disease and other dementing disorders of older age are invited. Applicants are particularly encouraged to develop improved case finding techniques, to evaluate and refine diagnostic criteria, to develop diagnostic screening procedures, and to further advance epidemiological sampling and design.

MECHANISMS OF SUPPORT

Applicants may use the Research Project Grant (R01), Research Program Project (P01), First Independent Research Support and Transition Award (R29), Research Career Development Award (K04), Clinical Investigator Award (K08), Academic Award (K08), Physician Scientist Award (K11 and K12), and the National Research Services Awards. Prospective applicants are encouraged to communicate with the NIA project officer listed at the end of the announcement regarding the appropriate funding mechanism. Experienced senior investigators are particularly encouraged to consider the submission of Research Program Project applications.

APPLICATION AND REVIEW PROCEDURES

Applicants may obtain information and the appropriate application kits from their institution's grants office or by contacting:

Office of Grants Inquiries
Division of Research Grants
National Institutes of Health
Bethesda, Maryland 20892
Telephone: 301/496-7441

Although a letter of intent is not a prerequisite for applying, prospective applicants are encouraged to consult with the project officer regarding the scientific goals, design and subject population of the proposed study.

On item 2 (Response to a Specific Program Announcement) of the face (first) page of the application, applicants should enter: NIA Program Announcement-Epidemiology of Alzheimer Disease.

Applications should be submitted according to the receipt deadlines for the funding mechanism chosen.

Applications will be received by the NIH Division of Research

Grants and responsive applications will be assigned to the NIA. However, it should be recognized that other NIH components, such as NINCDS, and the NIMH also have responsibility for supporting Alzheimer Disease related research. Applications will be assigned to the appropriate group for review and will be reviewed in accordance with the usual NIH peer review procedures. The review criteria are the traditional considerations underlying scientific merit. Following study section review, the applications will be evaluated by the National Advisory Council on Aging. Awards will be made on a competitive basis with all applications competing for NIA funding.

INQUIRIES

All questions and correspondences should be directed to:

Teresa Sluss Radebaugh, Sc.D.
Diagnosis and Epidemiology of Alzheimer Disease
Neuroscience of Aging Branch
National Institute on Aging
Building 31, Room 5C27
9000 Rockville Pike
Bethesda, Maryland 20892
301/496-9350

PROGRAM ANNOUNCEMENT: THE DIAGNOSIS OF ALZHEIMER DISEASE

National Institute on Aging, National Institute of Mental Health, National Institute of Neurological and Communicative Disorders and Stroke

BACKGROUND

Alzheimer disease (AD) is a progressive degenerative disorder of insidious onset, characterized by memory loss, confusion, and a variety of cognitive disabilities. It may occur as early as the age of 40 years, but is most commonly seen after the age of 60 years. Its prevalence seems to be increasing as the average life expectancy increases. In its early stages in elderly persons, the diagnosis is difficult. In its later states, AD is sometimes mistaken for other kinds of dementias and mental diseases. Incorrect diagnosis is thought to be common, perhaps ranging from 10 percent to 30 percent in the general medical population (National Institute on Aging Task Force, 1980).

Early and accurate diagnosis of Alzheimer disease has a major impact on the progress of research on dementia. To address the problems involved in AD in its earliest stages, the National Institute on Aging, the American Association of Retired Persons, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health jointly sponsored a workshop for planning research. The purpose of the meeting was to identify the most important scientific research opportunities and the crucial clinical and technical issues that influence the progress of research on the diagnosis of AD. The recommendation of the participants was published as a conference report in the Archives of Neurology. See "Diagnosis of Alzheimer's Disease," Z. S. Khachaturian, Arch. Neurol. 1985, 42:1097-1103.

RESEARCH GOALS AND SCOPE

The purpose of this announcement is to stimulate further research focusing on the specific scientific issues identified in the above-referenced conference. Progress in understanding and diagnosing AD will most likely come about through amassing, evaluating, and comparing data and material from many sources. All data collected, both retrospective and prospective, will be maximally useful only so long as they are careful screened for accuracy of diagnosis, relevance, and reliability and are comparable across studies.

The following are some of the topics that are of particular programmatic interest to the three institutes. These are merely an illustration of topics. Applicants should not be limited to them.

o Diagnostic Screening: There is an immediate need for improved diagnosis and diagnostic screening for AD. However, the diagnosis of and screening for AD will continue to be difficult and sometimes inaccurate until we achieve a better understanding of the normal aging process. There exist no consistent, established values for what constitutes cognitive impairment and memory loss with advancing years; nor are the neurologic changes, the neurochemical changes, the neurophysiological changes, or the gross and fine anatomical changes that accompany normal aging well enough understood to provide a firm base for determining abnormal changes. The major difficulty in diagnosing AD involves the definition of the disease itself and its varied and, at times, subtle manifestations; AD remains a combined clinicopathologic diagnosis. The relationship between neuropsychological, neuroradiological, and neuropathologic indexes of the disease is not well understood. A continuing effort to define the disease precisely and to develop methods of definitely distinguishing AD from other nervous system diseases must remain the substrate of all research in the field.

o Neuropsychological Diagnosis and Other Behavioral Measures: There is a need for the development of neuropsychologic and behavioral tests and markers for AD. Practical screening for AD in the elderly population requires reliable neuropsychological markers. Measures of very subtle changes in behavior that are the first signs of aberration to be noticed by family members are needed.

Neuropsychological testing involving abilities other than cognitive ones may also be useful and important. Tests of first-order capabilities such as visual perception, reaction time, or motor ability might be closer to measuring substrate levels of central nervous system integrity or disability without the complication of trying to measure abstract-conceptual-cognitive behavior.

o Biological and Chemical Markers: Sensitive and specific biological and chemical markers to identify those at high risk of AD and those in the very early stages of AD are required, preferably derived from extraneural sources such as urine, saliva, blood (cells or plasma), CSF, or fibroblast cell cultures. Before any marker is proposed or made available, it is essential to validate it against the neuropathological diagnoses and all other significant disease signs.

Techniques of molecular genetics provide a promising new approach for understanding AD diagnosis-etiology-therapy, especially in view of the evidence that there is a familial factor present in the disease.

o Neuroimaging: There is a need to understand and to resolve the conflicting data produced by studies using different noninvasive imaging instruments, particularly brain localization of the imaged data, and stereotactic location of prominent landmarks in the brain using methods borrowed from current neurosurgical technology.

o Neuropathological Markers: The relationship of plaques and neurofibrillary tangles to premortem cognitive function and to the pathogenic mechanisms of AD must be clarified. While standards have been established for the neuropathological diagnosis of Alzheimer disease, questions still remain. For instance, if a presumptive diagnosis of dementia resulting from Alzheimer disease is made pre-mortem, the presence of plaques and tangles at autopsy is generally considered confirmatory. However, the frequency of plaques and tangles in representative population samples of persons who were cognitively intact prior to death is unknown.

Longitudinal epidemiological studies with post-mortem investigation are required. Longitudinal studies collecting detailed information on individuals already suffering from AD and studies involving general populations of elderly persons may provide information on premorbid events and conditions of those who might come down with the disease.

MECHANISMS OF SUPPORT

Applicants may use the Research Project Grant (R01), Research Program Project (P01), First Independent Research Support and Transition Award (R29), Research Career Development Award (K01, K02, K04 and K05), Clinical Investigator Award (K08), Academic Award (K07 and K08), Physician Scientist Award (K11 and K12), and the National Research Services Awards. Prospective applicants are encouraged to communicate with the institute project officer listed at the end of the announcement regarding the appropriate funding mechanism. Experienced senior investigators are particularly encouraged to consider the submission of Research Program Project applications.

APPLICATION AND REVIEW PROCEDURES

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Office of Grants Inquiries
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National Institutes of Health
Bethesda, Maryland 20892
Telephone: 301/496-7441

Although a letter of intent is not a prerequisite for applying, prospective applicants are encouraged to consult with the project officer regarding the scientific goals, design and subject population of the proposed study.

On item 2 (Response to a Specific Program Announcement) of the face (first) page of the application, applicants should enter: NIA Program Announcement - Diagnosis of Alzheimer Disease.

Applications should be submitted according to the receipt deadlines for the funding mechanism chosen.

Applications will be received by the NIH Division of Research Grants and responsive applications will be assigned to the appropriate Institute. Multiple assignments are possible. It should be recognized that other NIH components, such as the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health, the Alcohol, Drug Abuse and Mental Health Administration, also have responsibility for supporting AD related research. Applications will be assigned to the appropriate group for review and will be reviewed in accordance with the usual NIH peer review procedures. The review criteria are the traditional considerations underlying scientific merit. Following study section review, the applications will be evaluated by the National Advisory Council. Awards will be made on a competitive basis with all applications competing for NIA funding.

INQUIRIES

All questions and corresponsences should be directed to:

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The CHAIRMAN. Ms. Carolyn Gray, Acting Deputy Assistant Secretary for Human Development Services, accompanied by Ms. Carol Fraser Fisk, Commissioner of the Administration on Aging.

Please proceed, Ms. Gray.

STATEMENT OF CAROLYN GRAY, ACTING DEPUTY ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES; ACCOMPANIED BY CAROL FRASER FISK, COMMISSIONER, ADMINISTRATION ON AGING

Ms. GRAY. Thank you very much, Mr. Chairman. We are pleased to be here today and to have the opportunity to discuss with you the proposed fiscal year 1988 budget for the Office of Human Development Services and what it means for older Americans.

As you are aware, the Administration's 1988 budget includes a generic appropriation request of $2.2 billion for all of the discretionary social service activities administered by OHDS. Let me say first and foremost that this generic request is not a block grant consolidation proposal. It does not indicate any lack of commitment or focus on our part to the importance of the Older Americans Act programs, nor is it intended to change the operations of the Older Americans Act. We recognize and anticipate the great rise in the numbers of older Americans, and these programs remain a priority.

I want to discuss the purposes of the generic appropriation request, and they are, one, to simplify the budget decisionmaking process; two, to focus resource allocation decisions on that overall direction for Federal policy for social services; and, three, to adopt an approach similar to one used by Congressional budget committees in assigning funding allocations to broad functional categories.

It is important at this juncture to note that the Older Americans Act will retain its separate statutory program authorities, including State formula allotments and eligibility for services. However, under the generic appropriation for social service activities, to the extent and degree that Congress does not earmark funding, HHS will have the flexibility to use its program expertise to determine specific funding levels and initiatives.

The Older Americans Act programs have been included in this generic appropriation request for a number of reasons. They share common objectives with other programs that we administer which are designed to help people gain self-sufficiency and to the fullest extent possible, to help them lead productive and useful lives. In addition, the target populations of these programs are very similar. The programs serve persons of low income, the abused, neglected, those most vulnerable, or at risk. And as you know, the intent of these programs is for the Federal Government to augment the financial resources of State, local, and nonprofit organizations.

Mr. Chairman, the great challenge that faces us, as we've already heard this morning, is the rapid growth of the elderly population. Between 1980 and the year 2000, the population over 60 years of age is expected to increase approximately 27 percent, and will represent approximately 17 percent of the population. Indeed, by the year 2030 one in four Americans will be over the age of 60, about 82 million older persons.

Consequently, the major challenge will be to focus scarce public resources on those older persons most in need and to focus our efforts on persons within their communities.

In order to meet these challenges, the Administration on Aging is committed to working with families, communities, support systems, and the private sector to enhance awareness among all of us as to the aged in the general public. There also must be an increased sense of personal responsibility from each of us to help plan and prepare for our older years.

We believe that families are the backbone of our service system. I certainly experienced that this week, having been called out to an emergency surgery for my mother. We have to provide more care; but we must also see that families provide more care, love and attention than all of the public or private programs combined. However, this family care-giving network may develop strains in the near future because the composition and the lifestyle of the American family is changing so significantly. Thus, AOA is working to develop and implement another series of special initiatives focused on family care-giving.

In conclusion, Mr. Chairman, our 1988 budget request is a commitment to continue promoting management efficiency in the Older Americans Act programs. It is a commitment to encourage the self-sufficiency of each individual. It is a commitment to enhance economic opportunities for all older Americans and a commitment to uphold the individual and family values which are the foundation of our Nation.

I can assure you that these commitments are carried equally by Dr. Elder, Assistant Secretary of Human Development Services designate, Commissioner Fisk, and myself. We and this Administration will see that a strong, viable, and responsive Older Americans Act is in the future of our Nation. We look forward to working with you and your committee members to assure that every community in this Nation is a place where all of us can feel secure and healthy in growing older.

I thank you, sir, and I welcome any questions you may have.

[The prepared statement of Ms. Gray follows:]

STATEMENT BY

CAROLYN DOPPELT GRAY
ACTING DEPUTY ASSISTANT SECRETARY FOR
HUMAN DEVELOPMENT SERVICES

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

March 13, 1987

WASHINGTON, D.C.

Good morning Mr. Chairman, I am pleased to have the opportunity to discuss with you and Committee Members the proposed FY 1988 budget for the Office of Human Development Services and what it means for older Americans.

As you are well aware, the Administration's FY 88 budget includes a generic appropriation request of $2.2 billion for all of the discretionary social service activities administered by OHDS. Let me say first that this generic request is not a block grant consolidation proposal, nor is it intended to change the operation of existing Older Americans Act programs. The generic request does not indicate any lack of commitment or focus on our part as to the great importance and priority of the Older Americans programs administered by the Department. As we anticipate the growth in size of the senior citizen population in America, these programs remain a priority.

The purpose of the generic request is to simplify the budget decision-making process and to focus resource allocation decisions on the overall direction of Federal policy for social services rather than on specific line item programs.

Therefore, the generic request of $2.2 billion is not allocated to each of 26 separate line items displayed in the past. The generic request reflects the total proposed level of funding committed to discretionary social services activities. Budgeting in this manner is simply designed to foster a more comprehensive consideration of the entire human development services function -- to generate a broader view of our Federal spending priorities. The generic request is a logical extension of the budgetting approach formed by Congressional Budget Committees which assign funding allocations to broad functional categories. We invite Congress to selectively identify priorities within the $2.2 billion requested level of effort.

The Older Americans Act programs will retain their separate statutory program authorities, including State formula allotments and eligibility for services. However, under a generic appropriation for social services activities (to the degree Congress did not earmark funding), HHS would have the flexibility to use program expertise to determine specific program funding levels and initiatives, thus taking advantage of emerging opportunities to best serve older Americans, children, the developmentally disabled, and Native Americans. Congress will be informed immediately of funding determination for specific social services activities once they are made.

The Older Americans Act programs have been included in a generic request because they share common objectives with the other programs that HDS administers. These programs are all designed to help maintain self sufficiency, help them lead productive and useful lives, and help them overcome neglect or abuse. The target populations of the programs are also similar: low-income, abused, neglected, or at-risk individuals. In each of these programs, the Federal Government augments the financial resources of State, local, and non-profit organizations.

The Older Americans Act programs which are administered by the Administration on Aging are a tremendously vital part of this nation's support for our older people. As we begin the third decade of implementing this very successful legislation, we are undertaking a critical examination of what has been accomplished and what remains to be accomplished. We must address the changing demographics of the elderly while ensuring that the nation's neediest older people continue to receive the assistance they need to remain self-sufficient and independent within their own communities.

Mr. Chairman, as you will know, one great challenge that faces us is the rapid growth of the elderly population. Between 1980 - 2000, the population over age 60 is expected to increase approximately 27 percent, and will represent 17 percent of the U.S. population. This may climb to more than one in four by the year 2030 -- nearly 82 million older persons. This "graying" of American society will impact significantly upon every major social institution -- particularly social services -- in the decades ahead.

A second major challenge will be to focus scarce public resources on those older persons most in need of assistance. Frequently, many of these persons -- the most vulnerable -- are women, minorities, the very old, and low income persons.

In order to meet these challenges, the Administration on Aging is committed to working for increased involvement by families, communities, service providers, and the private sector as well as building more positive attitudes and perceptions of the aged in the general public. There must also be an increased sense of personal responsibility for planning for one's older years.

Currently, Older Americans Act programs serve an estimated nine (9) million older persons annually. In FY 1985, 16.4 percent of all participants were racial and ethnic minorities and 43 percent were low income. In addition, during FY 1985 over 149 million congregate meals were served to over 2.9 million elderly while 75.5 million meals were provided to almost 700,000 homebound older people.

Largely as a result of the Older Americans Act of 1965, there is a network of State Agencies on Aging including one in every state, and there are 670 local Area Agencies on Aging around the country. These agencies are working at the local level with thousands of service providers to develop comprehensive and coordinated systems of care for older people in every community. The agencies are in different stages of development and have met with varying degrees of success. However, all are working to blend federal, state, and local funds and programs with the energies of community caregivers to produce a system that responds to local needs.

Conditions and needs of older people in a large city like Boston differ from those in a suburban community in Oregon, a rural farming community in Kansas, a retirement community in Florida, an American Indian reservation in New Mexico, or a Hispanic community of East Los Angeles. Nevertheless, State and Area Agencies on Aging are striving to develop responsive systems which share some common elements and which provide services that are comprehensive and of high quality. We believe that community systems that share the following 10 elements will be the most successful:

1. Visibility -- Each community should have a visible point of contact so that people in need of assistance know where to go for help, information, or a referral. For example, many communities offer a central information and referral service with a well-publicized telephone number.
2. Range of Options -- Communities should offer a broad continuum of services including in-home health and personal services, transportation, counseling, housing assistance, jobs programs, leisure activities, volunteer opportunities, and meals programs, as well as high quality short and long-term institutional care.
3. Accessibility -- A responsive community system will be accessible to all older people, regardless of how independent they may be or how much income they may have. Adequate transportation should be provided for

people who no longer drive and who cannot get around in the community. Any barriers such as unnecessary or complicated paperwork or poorly trained staff should be removed.

4. Flexibility -- The system should be able to respond with assistance tailored to the needs and resources of each individual. In some communities, this is possible through the efforts of case managers who work with individual older people and their families to develop assistance plans and continually ensure that the assistance received is effective and appropriate.

5. Targeting -- A responsive system will provide special assistance to the most vulnerable older people, those most in danger of losing their independence and will respond to the unique needs of the poor, minority, handicapped, isolated, and rural populations.

6. Pooling of Resources -- All of the public, private, voluntary, and personal resources in the community are committed to supporting the system.
7. Collaboration -- The various partners in the community system--public, private, voluntary, religious, and fraternal organizations, as well as older people and their families, neighbors, and friends--work together with common goals, sharing information and resources whenever possible.
8. Coordination -- Whenever a contact is made with the system by or on behalf of an older person, no matter where the contact is made, the person or organization being contacted can provide information about or referrals to other parts of the system. For people who need help, dealing with a coordinated, responsive system is critical.

9. Leadership -- Each community should have an agency, organization, or individual with the responsibility to convene all interested parties, assess community needs, design solutions, track overall success, stimulate change, and plan for the community's response today and in the future. In many communities, the Area Agency on Aging has this leadership role.

10. Uniqueness -- The shape of a responsive community system is determined in part by the elements described above and in part by the unique and changing nature of the local community and its older population.

We believe that families are the backbone of our service system. They provide more care to older people than all public and private programs combined. Families also provide the love and attention which can sometimes be lost in service programs despite our best efforts.

Therefore we believe that a responsive community system must do everything it can to support the families of older people. Family members will undoubtedly continue to provide asmuch care as possible. Thankfully, that is human nature. However, the family caregiving network may develop strains in the near future because the composition and lifestyle of the average American family is changing so significantly.

Therefore, the Administration on Aging will continue to work to stimulate the development of responsive community systems. This past year the Administration on Aging developed a community checklist that can be used by leaders and citizens of every community in the nation to assess their local systems and thereby determine if current systems-building and improvement efforts at the local level are sufficiently responsive to the needs of older people. The checklist can be a useful tool in heightening awareness of community responsibility toward the special needs of the elderly and toward the necessity of forging systems of care that are appropriate to the individual elderly person's needs, capacities and resources.

A major responsibility of the AoA is to provide leadership -- to other Federal agencies, and to the national network on aging regarding to their respective efforts on behalf of the elderly. Toward this end, AoA has developed and implemented a variety of special initiatives aimed at improving the quality of life for older persons. Examples of special initiatives undertaken during FY 1986 are as follows:

0 The National Health Promotion Campaign: Recognizing the personal and societal benefits of healthier lifestyles for older persons, AoA and the Public Health Service (PHS) are continuing a multi-year effort to encourage States and local communities to develop ongoing health promotion activities for older Americans.

0 Preparing the Health Care Community for the "Graying of America": AoA and the Public Health Service have expanded their cooperative efforts to launch a multi-year effort to prepare the health community for the graying of America. This will be accomplished through improved education and training and a public information campaign (beginning with a "Surgeon General's Workshop") to increase awareness in the health care community about the needs of older people and to encourage and recruit young people to enter fields that provide or administer health related services to older people.

0 Caregiver Initiative: As part of AoA's strategy to target services on the vulnerable elderly, the Agency has launched an initiative to improve the capacity of caregivers who provide critical assistance to

functionally impaired older persons. We recognize that growing numbers of vulnerable older persons are cared for in their homes by family, friends, and neighbors, many of whom have insufficient information, training, and support to perform their roles in a fully effective manner.

0 Minority Participation Initiative: We are continuing to assist the Aging Network to increase minority participation in Older Americans Act programs. We have worked with four national minority organizations: The Asociacion Nacional Pro Personas Mayores; National Center on Black Aged; National Pacific/Asian Resources Center on Aging; and the National Indian Council on Aging. A summary of minority participation activities was disseminated by AoA to the aging network and we expect the States to replicate some of these models.

0 Technical Information Initiative: AoA has realized the need for the systematic sharing of technical information among members of the aging network about projects and efforts which benefit older people. For example, AoA regularly distributes Aging Program Notes which contain descriptions of successful programs with demonstrated effectiveness. We are also continuing to give a high priority to increasing the utilization of the results of Title IV Research and Development projects with special emphasis on Alzheimers' Disease, elder abuse, and housing.

0 Aging Network Visibility Initiative: AoA is working to make the Area Agencies on Aging more visible to older people and their friends and relatives in the community. This summer we will distribute public service announcements about Area Agencies on Aging and how they can help older people.

0 Religious Group Linkages: AoA is working with national religious organizations to increase the involvement of local religious groups, including churches and synagogues, in improving community systems of care for the elderly.

Mr. Chairman, the reauthorization of the Older Americans Act this year will be very important in ensuring our ability to develop responsive systems. We wholeheartedly support reauthorization, and I can assure you of both my personal commitment, and that of this Administration, to a strong, viable, and responsive Older Americans Act. We will soon send to Congress proposed legislation for reauthorizing the Older Americans Act and target services to the most vulnerable elderly.

In conclusion, the FY 1988 budget request builds on the accomplishments of the past six years: promoting management efficiency in Older Americans Act programs; encouraging self-sufficiency and economic opportunity for all older Americans; and upholding the individual and family values which are the foundation of our nation.

I look forward to our working together to assure that every community in this great nation is a place where any of us can feel secure in growing older. I will be pleased to respond to any questions you or members of the committee may have.

Thank You.

The CHAIRMAN. Well, thank you. But I don't care what you call it, block grant or not, the term doesn't offend me if that's what we want it to do.

Now, is this the same amount of money, this $2.2 billion—is it the same amount of money that we're spending this year?

Ms. GRAY. Sir, it's around $34 million less than this year overall, considering all the programs. That includes programs for the developmentally-disabled and Native Americans, for Head Start and child welfare services in addition to the Older Americans Act programs.

The CHAIRMAN. Well, what do you mean? We're going to increase—if we followed your recommendations wouldn't we increase Head Start by $20 million?

Ms. GRAY. Yes, sir.

The CHAIRMAN. So it's a $34 million reduction in other programs?

Ms. GRAY. Yes, sir.

The CHAIRMAN. Well, which ones do you recommend we cut?

Ms. GRAY. Sir, at this point in time we will wait until the appropriation level has been received. And to the extent that Congress has not earmarked funds, we will then use our department's program expertise to allocate funds among the various competing needs and emerging opportunities.

The CHAIRMAN. Somehow I think we'd better earmark because I don't get a clear picture of what you're doing. Can you tell me what you're going to do?

Ms. GRAY. We hope to eliminate any overlapping or duplication of authorities. We can say, in speaking to the Older Americans Act programs, that direct services are one of our priorities. They have been, and they will remain so; and therefore meals and supportive services will be high on the list.

The CHAIRMAN. You say in your testimony, 149 million meals were served in congregate centers? Is that correct?

Ms. GRAY. Yes.

The CHAIRMAN. Why do you think it's so low?

Ms. GRAY. Why do we think it's so low? I think that's a fairly significant figure. Moreover, I think that we have a high rate of return on our investment, in that the dollars we put into local programs generate a good deal of support from other sources.

The CHAIRMAN. How much did it increase over the previous year?

Ms. GRAY. How much did the number of meals increase?

The CHAIRMAN. Yes.

Ms. GRAY. I don't have the percent before me, but it's an increase of about 30 million meals.

The CHAIRMAN. From last year?

Ms. GRAY. Yes.

The CHAIRMAN. Now, you think it's a fairly high figure. Let me point out that you also, in the same testimony, have 71 million meals, in Meals On Wheels?

Ms. GRAY. In home delivery meals, yes.

The CHAIRMAN. Home delivery meals. Now, doesn't that strike you as a rather odd ratio, that somehow we've got 71 million being delivered right to the homes and only 149 million, roughly twice as much, in congregate meals?

Ms. GRAY. We've seen an increase in the number of home-delivered meals over time, and we allow the States the flexibility to transfer funds between those two nutrition programs. It's up to the States to make such decisions in terms of the most vulnerable populations in their communities. I don't know that I would go so far as to say that it was an odd ratio, but rather that I think it does reflect what they see as needs in the local communities we're serving.

The CHAIRMAN. What do you think you invest per meal in congregate meals?

Ms. GRAY. In congregate meals, the average meal cost nationwide is about $0.55——

The CHAIRMAN. Out of that kitty, how much do you think you invest in meals?

Ms. GRAY. How much do we invest? We put in a varying percentage depending on where you are in the country.

The CHAIRMAN. Ten cents?

Ms. GRAY. No, a good deal more than that.

The CHAIRMAN. Twenty cents?

Ms. GRAY. It depends on the locality. In some cases, we put in 100 percent of the meal cost; in other cases we put in a good deal less. It depends on how many other sources of funds are available and how much program income is generated.

The CHAIRMAN. It's general practice for everybody to kick in a buck?

Ms. GRAY. I beg your pardon?

The CHAIRMAN. It's a general practice at senior citizen centers for everybody to kick in a buck that can afford it, as they pass to get their meal.

Ms. GRAY. It depends on the site. We encourage voluntary contributions in every site in accordance with the law. Some sites have higher contributions than others.

The CHAIRMAN. I'm telling you that, it's a general practice to kick in a buck if you can afford it. As it happens, most people kick in a buck. So you really never pay 100 percent unless you've got some congregate where that isn't the practice, of asking to contribute anything. But we're talking about meals that are probably about a $2.50 meal, actual cost. Now, how much of that is out of commodities that are donated by the Department of Agriculture?

Ms. GRAY. I don't have those figures with me, but I'd be glad to provide them.

The CHAIRMAN. But you're well aware that they donate it?

Ms. GRAY. Yes sir.

The CHAIRMAN. Now, what I'm telling you is that I think that 149 million is not nearly adequate for what we should be doing in congregate meals. Can you tell me how we can improve on that?

Ms. GRAY. We've seen growth in the number of meals even as the Federal investment has remained level through a variety of program initiatives. We've worked with the States and the area agencies on budgeting improvements, as well as on better ways to process and handle food. And that, I think, has gone a great distance. But certainly, you are correct and we shall continue to do more to try to increase the number of meals.

The CHAIRMAN. Have you ever looked at the possibility of using more commodities? And are there ever any guidelines ever sent out to these area directors that tell them how to get those commodities?

Ms. GRAY. Yes sir, we have. And we've worked with the Department of Agriculture to improve the ease of handling of commodities so that they are more useful to the local service providers.

The CHAIRMAN. Well, have you ever suggested—or have you ever even contemplated—that at these congregate meals, that those that are there be encouraged to take something home?

Ms. GRAY. That is done in some portions of the country.

The CHAIRMAN. Have you encouraged it?

Ms. GRAY. Yes sir.

The CHAIRMAN. In what way?

Ms. GRAY. By sending information and policy guidance to the States and area agencies encouraging them to do so.

The CHAIRMAN. I think most of them are under the impression that if they divvied up a little hunk of cheese to take home, they would be violating some regulation.

Ms. GRAY. Well, that's an impression we certainly wouldn't want to have continue. With donated commodities, we certainly want our providers to be working with that program and want older Americans taking full advantage of it.

The CHAIRMAN. I would encourage you to make that a specific recommendation as you communicate with the States with any—do you see these area directors? I imagine you do, don't you?

Ms. GRAY. Yes sir.

The CHAIRMAN. And with the area directors?

Ms. GRAY. Yes.

The CHAIRMAN. And I'd like to see some evidence of that because I don't think it's a clear-cut policy, and I think under Federal law it is one that's permitted and one that should be utilized.

Ms. GRAY. I agree with you, yes.

The CHAIRMAN. So can I see some evidence, then?

Ms. GRAY. Certainly.

The CHAIRMAN. All right.

Now, why do you want to reprogram some of the Title IV funds, Ms. Gray?

Ms. GRAY. The Title IV funds reprogramming reflects unexpected mandatory cost increases in back claims from the States under the Foster Care and Adoption Assistance programs. Those back claims amount to about $167 million. We did not want to come to Congress requesting more money, given the tight budget constraints and the Federal deficit that we are already incurring. Therefore, we have offset the costs with funds spread among child welfare services, the aging research, the independent living, and the Title XX programs.

The reprogramming also offsets the costs of the Federal pay raise and the Federal employment retirement system.

The CHAIRMAN. How long are you going to wait to find out that we're not going to do that?

Ms. **Gray**. Well, sir, we're waiting to have Congress act on our request.

The **Chairman**. And then you're going to move to utilize the funds as we directed?

Ms. **Gray**. We will certainly take everything into consideration that comes from the Hill. We always do.

The **Chairman**. Doesn't this adversely affect the program by delaying it?

Ms. **Gray**. No, sir, not at all. We feel that we have sufficient funds. Look at the high quality research that is ongoing in the Administration on Aging; and as you've heard this morning, both from NIH and HCFA, there are other high quality programs of research continuing within our own department.

The **Chairman**. Have you detailed out any staff?

Ms. **Gray**. From time to time within our Office of Human Development Services, we do detail staff.

The **Chairman**. Where do they go?

Ms. **Gray**. We many times detail within our own Office of Human Development Services.

The **Chairman**. Where else?

Ms. **Gray**. Let's see. At this point we have someone on a detail to work with the Pan American Games, to work there——

The **Chairman**. How does that fit in?

Ms. **Gray**. And we also have one, I'm told, at Veterans Administration.

The **Chairman**. How does the Pan American Games work in with your detail?

Ms. **Gray**. We will provide you a report for the record.

The **Chairman**. I don't understand how it fits in. Maybe I lost track of something. Why would you detail somebody to the Pan American Games?

Ms. **Gray**. The department itself, sir, is very interested in the Pan American Games and the correlation of the sports and good health. As we look across all our programs—one of them being for the developmentally-disabled—we are looking at programs for sports. We have a new one running for children. We think it's very, very important to use sports to develop a healthy body and a healthy mind.

The **Chairman**. To the Pan American Games?

Ms. **Gray**. To all sports, sir.

The **Chairman**. Has this been done before?

Ms. **Gray**. Sir, I don't have that information available. I'd be happy to find out and supply it for the record.

[Material to be supplied follows:]

HDS has not detailed anyone to the Pan American Games.

HDS has detailed one person under the Intergovernmental Personnel Act to Partners of the Americas. This is a voluntary organization founded in 1964 under the Alliance for Progress and dedicated to improving the quality of life in the Western Hemisphere through private sector cooperation.

In recognition of the Tenth Pan American Games, Congress passed S.J. Res. 350 (Public Law 99-356) which designated 1987 as the "National Year of the Americas" and authorized and requested the President "to issue a proclamation calling upon Federal, State, and local government agencies, private organizations, and the people of the United States to observe the year with appropriate programs, ceremonies, and activities." The law was enacted on July 3, 1986 and the President subsequently issued the proclamation.

Partners of the Americas is co-sponsoring certain activities in celebration of the "National Year of the Americas" in cooperation with PAX/Indianapolis, the organizing committee of the Tenth Pan American Games. As an official people-to-people organization of the Games, Partners of the Americas works to promote the spirit of hemispheric goodwill and friendship. The organization pairs U.S. States with nations of Latin American and the Caribbean into permanent partnerships. Through 56 such partnerships, volunteers in 44 U.S. States and 28 Latin American and Carribean nations share their skills and expertise to carry out economic and social development projects, as well as cultural and sports exchanges.

Currently, approximately 17,000 citizens contribute their time to the Partners' programs. In any given year, 5,000 of these volunteers are exchanged by the partnerships to work on projects in agriculture, community development, culture and arts, education, emergency preparedness, health care, job training, rehabilitation and special education, small business development, sports, and youth development programs.

Some 1,500 Partner projects are conducted annually. Valued at nearly $50 million, these projects are estimated to benefit more than 10,000 people a year.

The individual from HDS will help conduct a health professional exchange program and an intenational health seminar. This individual was selected for this assignment due to his professional experience and expertise in international public health and disability programs.

The CHAIRMAN. Have you had some travel reductions at AOA?

Ms. GRAY. In AOA?

Carol, would you like to speak to that specifically?

Ms. FISK. We have received an allocation from the Assistant Secretary and we plan to use it as wisely as we can.

The CHAIRMAN. What does that mean, that you've had something from the Assistant Secretary?

Ms. FISK. We've received our travel allocation from the Assistant Secretary.

The CHAIRMAN. And what has that travel award been?

Ms. FISK. We have a dollar amount that has been awarded to us for use in support of our programs.

The CHAIRMAN. Has that been cut?

Ms. FISK. We received an amount. It has not been cut.

The CHAIRMAN. Has it been cut from last year, the amount you received?

Ms. FISK. I'd have to look at the figures, sir.

The CHAIRMAN. Have you ever looked at the figures of AOA as compared to others?

Ms. FISK. Sir, that's not available to me.

The CHAIRMAN. It isn't available to you? We're of the opinion that AOA is of a pretty low priority. Is that right?

Ms. GRAY. Senator, I might say that there have been overall reductions in travel, but they've been across all the program areas in the department. AOA is one of them, but they really have hit all of the program areas to meet, again, our tight budget constraints.

The CHAIRMAN. Generally, I think people in the bureaucracy are forced to travel too much. But we have a concern that AOA has less than 5 percent of OHDS's travel allotment, and it has responsibility for 12 percent of OHDS's program funds. And we're of the opinion that AOA is out of sync within the department, and that there has been, really—there hasn't been enough. I look at a lot of other departments on other committees that have jurisdiction over them, and I sometimes find that I think they're whipping these people around the country and around the world too much for their own good. But we're of the opinion that AOA is restricted more than it should be, and more percentage-wise than others under your command, Ms. Gray.

Ms. **Gray**. Well, I understand what you're saying, sir. I think there's one important feature here, and that is the fact that many of the AOA programs are largely formula programs, and therefore the labor intensity of them may be distinguished from other programs that are not necessarily formula grant programs.

The **Chairman**. Well, let me say on behalf of all of us here on the committee, let's give you time to look at it and then we'd like to get back to you on it.

Ms. **Gray**. All right, sir.

The **Chairman**. Thank you very much, Ms. Gray and Ms. Fisk.

Ms. **Gray**. Thank you, sir.

The **Chairman**. I will be submitting written questions to you, Ms. Gray, following the conclusion of this hearing.

[The questions and the answers thereto follow:]

JOHN MELCHER, MONTANA, CHAIRMAN

JOHN GLENN, OHIO
LAWTON CHILES, FLORIDA
DAVID PRYOR, ARKANSAS
BILL BRADLEY, NEW JERSEY
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JOHN B. BREAUX, LOUISIANA
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HARRY REID, NEVADA

JOHN HEINZ, PENNSYLVANIA
WILLIAM S. COHEN, MAINE
LARRY PRESSLER, SOUTH DAKOTA
CHARLES E. GRASSLEY, IOWA
PETE WILSON, CALIFORNIA
PETE V. DOMENICI, NEW MEXICO
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MAX I. RICHTMAN, STAFF DIRECTOR
STEPHEN R. McCONNELL, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

March 27, 1987

Ms. Carolyn Doppelt Gray
Acting Deputy Assistant Secretary
  for Human Development Services
Office of Human Development Services
Department of Health and Human Services
200 Independence Ave.
Washington, D.C. 20201

Dear Ms. Gray:

Thank you for appearing before the Senate Special Committee on Aging on March 13 and answering questions regarding the impact of the Administration's proposed budget for Fiscal Year 1988 on Federal agencies providing services to older Americans. Your testimony was helpful and we appreciated having the benefit of your views.

During the course of the hearing, you and the other Administration witnesses indicated that you would be willing to answer additional questions that Committee members did not have the opportunity to pose. Keeping your offer in mind, we request that you answer the following questions:

1. The budget documents from your office show a reduction of about $34 million across the 26 discretionary programs administered by OHDS, but they do not show where that money is going to come from. Please tell us specifically where you are going to get this $34 million in cuts.

2. The Assistant Secretary told the Labor/HHS Appropriations Subcommittee that the Department would maintain the funding for certain programs, including the Older Americans Act. Please outline exactly how much money you would allocate to each program.

3. OHDS has also stated that "the Congress is invited to selectively define priorities and will be informed promptly of specific funding decisions." Insofar as Congress does not define appropriations priorities, what would there be in law, except funding ceilings, minimums, or set-asides in authorizing legislation, to affect the funding levels the Department chooses for particular programs?

4. The minority participation rate for the Older Americans Act Title III-B Supportive Services program has dropped by 24.7 percent during this decade, from 21.9 percent in FY 1980 to 16.5 percent in 1985. A similar pattern exists for the Title III-C Nutrition Program for the Elderly.

   a. What reasons account for this decline in the minority participation rate?

   b. What steps does the Administration plan to take to correct this problem?

5. You have indicated your intent to provide an additional $20 million to the Headstart Program. While these additional funds are no doubt badly needed:

   a. Will the $20 million come out of aging programs?

   b. If not, under your proposal, specifically what other program(s) would absorb the loss?

6. In light of the fact that Title IV of the OAA was originally funded at over $50 million and despite repeated Congressional rebuffing of Administration efforts to again halve these funds, do you believe that the purpose of this Title has been fulfilled? In other words, do we not need to continue to make special efforts to expand our knowledge of aging and to test innovative ideas in providing services?

   a. Is training in the field of aging no longer an important priority?

   b. Specifically, what do you plan to do in the area of training and research in FY 1988?

7. We understand that in 1984, AoA had 251 staff, and that now has been reduced to 175.

   a. Do you plan to further reduce AoA's staff in FY88 and if so, by how many?

   b. Are AoA's staff reductions in the same proportion to staff in other programs within OHDS?

   c. As follow-up to this hearing, the Committee would appreciate a list of FTEs that have been reduced and what their positions and responsibilities were, as well as the same information for those who have been detailed elsewhere.

8. You propose to transfer half of the funds for aging research to children's foster care and adoption assistance. How do you justify this transfer?

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by April 21, 1987. Therefore, we request that you relay your answers to the above questions prior to that date.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Best regards.

Sincerely,

John Melcher
Chairman

John Heinz
Ranking Minority Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Office of Assistant Secretary
Washington DC 20201

[illegible] 6 [illegible]

The Honorable John Melcher
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510-6400

Dear Mr. Chairman:

Thank you for the opportunity to appear before the Senate Special Committee on Aging and to testify regarding the impact of the Administration's proposed budget for FY 1988 on older Americans.

Per your request, attached are answers to the questions that you and other Committee members did not have an opportunity to pose during the hearing.

We appreciate your interest in our programs and are looking forward to working with you in the future.

Sincerely,

Carolyn D. Gray
Acting Deputy Assistant Secretary
for Human Development Services

Attachment

Question. The budget documents from your office show a reduction of about $34 million across the 26 discretionary programs administered by OHDS, but they do not show where that money is going to come from. Please tell us specifically where you are going to get this $34 million in cuts.

Answer. The Department has requested $1.51 billion for Head Start. Funding levels for other programs have not been determined but final decisions would be made based on program expertise and identified priorities.

Priority will continue to be placed on Head Start, Child Welfare Services, Aging services and nutrition programs, Developmental Disabilities grant programs, and financial assistance grants for Native Americans. Research and demonstration activities to support all the vulnerable populations served by OHDS social service programs will be continued. Congress would be notified of all funding level decisions as soon as they have been made.

Question. The Assistant Secretary told the Labor/HHS Appropriations Subcommittee that the Department would maintain the funding for certain programs, including the Older Americans Act. Please outline exactly how much money you would allocate to each program.

Answer. At this time there is no final decision on the funding levels for specific programs included in the Social Services Discretionary Activities line item in the FY 1988 Budget Request and, therefore, no reductions can be specifically identified.

After the appropriation level for the account has been determined, to the extent that Congress has not earmarked funds for specific programs, HHS will use its program expertise to determine specific funding levels to take advantage of emerging opportunities to best serve its populations and respond to priorities in the social services area.

Priority will continue to be placed on Head Start, Child Welfare Services, Aging services and nutrition programs, Developmental Disabilities grant programs, and financial assistance grants for Native Americans. The Administration intends to increase support for Head Start $20 million above the 1987 level. Research and demonstration activities to support all the vulnerable populations served by OHDS social service programs will be continued. The Congress would be notified of the funding decisions for all programs.

Question. OHDS has also stated that "the Congress is invited to selectively define priorities and will be informed promptly of specific funding decisions." Insofar as Congress does not define appropriations priorities, what would there be in law, except funding ceilings, minimums, or set-asides in authorizing legislation, to affect the funding levels the Department chooses for particular programs?

Answer. The purpose of the generic appropriation request is to focus the budget decision-making process on a total social services policy instead of on categorical program areas. The generic appropriation request is, in fact, modeled on the current procedures followed by the Congressional Budget Committees and thus would in no way diminish the appropriating responsibilities of Congress. Each of the program areas would continue to operate under their existing statutory authority and Congress would continue to have the option of earmarking funds in order to selectively define priorities.

Question. The minority participation rate for the Older Americans Act Title III-B Supportive Services program has dropped by 24.7 percent during this decade, from 21.9 percent in FY 1980 to 16.5 percent in 1985. A similar pattern exists for the Title III-C Nutrition Program for the Elderly.

a. What reasons account for this decline in the minority participation rate?

b. What steps does the Administration plan to take to correct this problem?

Answer. We are aware of the concerns expressed about the apparent decline in the participation of minorities in Title III programs, based on annual statistics published by the Administration on Aging since 1975. Our report to Congress on minority participation in Title III programs will be forwarded to the Committee under separate cover.

The report cites several reasons why annual participation statistics for minorities and the low-income elderly published prior to 1981 are not comparable to those reported in 1981 and subsequent years for both minorities and low-income elderly. For example, changes in Title III reporting methods have resulted in target group definitions or criteria for inclusion that were less inclusive after 1980. Further, our analysis of the more recent data indicates that minority participation in Title III has remained relatively stable over the past several years and that minorities are participating in numbers larger than their proportionate representation within the population age 60 and over.

We will continue to monitor closely the extent to which Title III services are being targeted to minorities and other populations with special needs. Our report to Congress summarizes the many investments made in this area, using Title IV resources, and we will continue to support new model projects and training activities designed to overcome barriers to participation by these special populations.

Question. You have indicated your intent to provide an additional $20 million to the Headstart Program. While these additional funds are no doubt badly needed:

a. Will the $20 million come out of aging programs?

b. If not, under your proposal, specifically what other program(s) would absorb the loss?

Answer. At this time we have not made final decisions on the funding levels for specific programs included in the Social Services Discretionary Activities line item in the FY 1988 Budget Request and, therefore, no reduction can be specifically identified.

After the appropriation level for the account has been determined, to the extent that Congress has not earmarked funds for specific programs, HHS will use its program expertise to determine specific funding levels and initiatives to take advantage of emerging opportunities to best serve its populations and respond to priorities in the social services area.

Priority will continue to be placed on Head Start, Child Welfare Services, Aging services and nutrition programs, Developmental Disabilities grant programs, and financial assistance grants for Native Americans. The Administration intends to increase support for Head Start $20 million above the 1987 level. Research and demonstration activities to support all the vulnerable populations served by OHDS social service programs will be continued. The Congress would be notified of the funding decisions for all programs.

Question. In light of the fact that Title IV of the OAA was originally funded at over $50 million and despite repeated Congressional rebuffing of Administration efforts to again halve these funds, do you believe that the purpose of this Title has been fulfilled? In other words, do we not need to continue to make special efforts to expand our knowledge of aging and to test innovative ideas in providing services?

a. Is training in the field of aging no longer an important priority?

b. Specifically, what do you plan to do in the area of training and research in FY 1988?

Answer. In order to fully respond to your questions about the Administration on Aging's Title IV program under the Older Americans Act, we are providing separate information about AoA's research and demonstration effort and about AoA's training program.

Title IV of the Older Americans Act authorizes funding for research and demonstration projects to identify, test, and evaluate new approaches for improving the well-being and independence of older persons. A primary objective in supporting research under Title IV is to develop the requisite knowledge and information base for State and Area Agencies on Aging--working in conjunction with public and private sector organizations--to build effective family and community-based service systems that provide a full continuum of care to the vulnerable elderly.

In addition, AoA is funding demonstration projects, which in turn, are aimed at testing the kinds of innovative concepts, models, and services that will make comprehensive, coordinated family and community-based care for older persons a reality.

AoA has consistently selected priority areas for research and demonstration projects on the basis of their relevance to the legislative mandates of the Older Americans Act and to the central mission outlined above. Recent research and demonstration initiatives, which will become fully operational in FY 1988, provide further evidence of AoA's continuing commitment to expand the nation's understanding and interest in, while strengthening the network's capacity for, building accessible and responsive family and community-based systems of care for older persons.

Current research and demonstration initiatives include:

- Assessments of Community Service Systems and the Roles of Area Agencies on Aging.

- Improving Linkages Between the Community Health Care System, Especially Hospitals and Community Health Centers, and the Community Supportive Service System.

- Increasing State Agency on Aging Leadership Capacity to Assist Alzheimer's Disease Victims and their Families.
- Improvement in Emergency Services.
- Improving Linkages with Long Term Care Facilities.
- Improving Targeting of Services to the Vulnerable Elderly.
- Tapping The Full Potential of Hospital Emergency Services for Older Persons.

The AoA education and training programs funded under Title IV seek to improve the quality of service and to help meet critical shortages of adequately trained personnel for programs in the field of aging. A primary objective of the Title IV training programs is to provide the necessary knowledge and skills to persons within State and Area Agencies on Aging as well as public and private sector organizations who are or will be employed in community-based service systems.

AoA selects priority areas for education and training projects on the basis of their relevance to the legislative mandates of the Older Americans Act and to the central mission outlined above. Recent training initiatives, which will become fully operational in FY 1988, substantiate AoA's continuing commitment to expand the nation's understanding and interest in, while strengthening the network's capacity for, building accessible and responsive family and community-based systems of care for older persons.

Current training initiatives include:

- Statewide short-term training and continuing education for professional and paraprofessionals.
- Encouraging the inclusion of aging content in professional academic training.
- Increasing the number of minorities in management positions in State and area agencies on aging as well as in other organizations impacting the elderly.
- Facilitating the development of linkages between State agencies on aging and other key State agencies to achieve more comprehensive and coordinated services for vulnerable older persons in the community.
- Orientation and education for elected officials on issues relating to the elderly and about what can be done to build responsive service systems.

Question. We understand that in 1984, AoA had 251 staff, and that now has been reduced to 175.

a. Do you plan to further reduce AoA's staff in FY 88 and if so, by how many?

b. Are AoA's staff reductions in the same proportion to staff in other programs within OHDS?

c. As follow-up to this hearing, the Committee would appreciate a list of FTEs that have been reduced and what their positions and responsibilities were, as well as the same information for those who have been detailed elsewhere.

Answer. The Administration has maintained a well established policy of reducing the size of the Federal bureaucracy. Because of this effort, the Office of Human Development Services has been under a virtually complete hiring freeze for a number of years. HDS has undergone a 35 percent reduction in total staff in recent years. Almost all of the organizations in HDS have sustained reductions in staffing throughout this time through normal attrition of staff.

Although the Administration on Aging has taken a reduction in staffing, so have other organizations in HDS. We have made every effort, and will continue to make every effort, to assign HDS staff resources to ensure that the HDS programs, including those of the Administration on Aging are well managed in accordance with the requirements of the authorizing legislation.

Attached is a list of positions in AoA that have been vacated since October 1983 (FY 1984), including those Headquarters employees currently on detail or extended leave.

This list reflects changes due to retirement, resignation from Federal service to take other employment and for other reasons, and transfers and promotions to other positions in HDS and in the Department.

This list, however, does not mean that the positions currently are vacant; nor would it be correct to infer that all the functions of these positions are not being performed.

Positions Vacated Since October, 1983

Headquarters

Title	Grade
Budget Analyst	GS-13
Social Science An	GS-13
Social Science Res An	GS-13
Aging Svcs Training Sp	GS-14
Secretary	GS-6
Program Analyst	GS-12
Correspondence Cntrl Ck	GS-6
Social Science Res An	GS-13
Program Analyst	GS-13
Editorial Asst	GS-7
Secretary	GS-6
Division Director	GM-14
Aging Services Prg Sp	GS-12
Deputy Commissicner	ES-4
Aging Svcs Trng Prg Sp	GS-13
Social Science Res An	GS-13
Program Analyst	GS-7
Program Analyst	GS-12
Division Director	GM-14
Secretary	GS-7
Division Director	GM-14
Social Science Res An	GS-13
Program Analyst	GS-13
Aging Svcs Training Sp	GS-13
Social Science An	GS-13
Secretary	GS-9
Aging Services Prg Sp	GS-13
Aging Services Prg Sp	GS-13
Social Science Res An	GS-13
Division Director	GM-14
Aging Srvcs Prg Spec	GS-12
Aging Services Prg Sp	GS-13
Secretary	GS-7
Clerk-Typist	GS-4
Social Science Res An	GS-13
Clerk Typist	GS-4
Special Assistant	GS-13
Management Assistant	GS-7
Secretary	GS-6
Clerk-Typist	GS-3
Budget Clerk	GS-4

Title	Grade
Division Director	GM-15
Actg Division Director	GM-15
Consultant	NA
Commissioner	EX-V
Secretary	GS-5
Nutritionist	GS-13
Public Inquiries Asst	GS-6
Aging Services Program Sp	GS-12
Social Science Res An	GS-12
Clerk-Typist	GS-4
Special Assistant	GS-13
Aging Srvcs Program Sp	GS-13
Program Analyst	GS-13

Headquarters AoA Employees Currently on Detail or Extended Leave:

Deputy Assoc Comm, OPD	GM-15 to HDS
Dir, Trng & Develop Div	GM-15 to VA
Writer/Editor	GS-12
Dir, Com Bsd Sys Imp Dv	GM-14 to HDS

Regional Employees who have left AoA Since October 1983:

Region I:

Secretary	GS-6
Dpty Regnl Prgrm Dir	GM-14
Secretary (Typing)	GS-4
Clerk-Typist	GS-3
Aging Program Spec	GS-12

Region II:

Secretary	GS-5
Aging Program Spec	GS-12
Aging Program Spec	GS-9
Aging Program Spec	GS-13
Aging Program Spec	GS-13
Clerk-Typist	GS-4

Region III:

Aging Program Spec	GS-13
Aging Program Spec	GS-13
Secretary	GS-6
Aging Program Spec	GS-13

Region IV:

Secretary	GS-6
Dpty, Reg Prog Dir	GS-14
Aging Program Spec	GS-12
Aging Program Spec	GS-12

Region V:

Aging Program Spec	GS-12
Aging Program Spec	GS-12
Aging Program Spec	GS-12
Aging Program Spec	GS-12
Clerk-Typist	GS-5
Aging Program Spec	GS-12

Region VI:

Aging Services Clerk	GS-5
Aging Program Spec	GS-13
Secretary	GS-5
Program Analyst	GS-13
Aging Program Tech	GS-7

Region VII:

Aging Svcs Program Sp	GS-12
Aging Svcs Program Sp	GS-12

Region VIII:

Clerk Typist	GS-4

Region IX:

Aging Program Spec	GS-13
Aging Program Spec	GS-13
Aging Program Spec	GS-13
Secretary	GS-5

Region X:

Secretary	GS-5
Aging Program Spec	GS-12

Question. You propose to transfer half of the funds for aging research to children's foster care and adoption assistance. How do you justify this transfer?

Answer. Although we recognize the importance of aging research, the budget deficit requires the Administration to make difficult policy choices. The Department proposed these transfers consistent with the policy of reducing non-service programs in order to maintain service programs.

Unexpected mandatory cost increases in the Foster Care and Adoption Assistance programs due to increased State Claims have resulted in the need for $165 million in supplemental funds for 1987. An additional $1.4 million in Federal administrative funds were required to pay for Federal employee pay raises and increased agency contributions for new Federal Employees' Retirement System.

Rather than add an additional $166 million to the Federal deficit, we requested only $43 million in new Budget authority and planned to offset the remaining $123 million with funds provided by Congress through reprogramming or transferring existing resources.

The Department's request to reprogram $1.4 million out of Aging Research Funds to pay for increased costs of pay raises and retirement has been denied by the House of Representatives.

Accordingly, these funds have been apportioned. The Aging title IV funds have been allotted to the Administration on Aging to support eligible discretionary grant applications submitted through the HDS Coordinated Discretionary Grants Process.

The $11.1 million proposed for transfer to help pay for prior year State claims for Foster Care costs is still pending with the Congress. A Congressional decision on this request will take place through the Appropriations process. The intent of this transfer is to help hold down the increase in additional funds needed to pay these Foster Care costs. Plans to use these aging research funds are being developed and if Congress denies the Administration's request, all aging research funds will be obligated by September 30, 1987.

The **Chairman**. Mr. Nelson Sabatini, Deputy Commissioner for Management Assessments, Social Security Administration.

STATEMENT OF NELSON SABATINI, DEPUTY COMMISSIONER FOR MANAGEMENT ASSESSMENTS, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY ELLIOT KIRSCHBAUM, DIRECTOR, OFFICE OF LEGISLATIVE AND REGULATORY POLICY

Mr. **Sabatini**. Thank you, Mr. Chairman.

I have submitted a statement for the record, and I will keep my opening remarks very brief.

The **Chairman**. OK. Thank you.

Mr. **Sabatini**. The 1988 budget that is before the Congress reflects a $13 billion increase over our 1987 budget, and reflects the President's commitment to assuring the continued integrity of the Social Security programs. This year's budget also reflects an estimated 3.5 percent COLA to be paid in 1988, and what is perhaps the best news in the budget is that the Social Security trust fund programs, which were on the verge of financial disaster approximately 5 years ago, or at the beginning of the 1980's, are no longer in that situation. The budget reflects steady growth in trust fund reserves and insures its continued financial integrity into the future.

Mr. Chairman, I'd be happy to answer any questions.

[The prepared statement of Mr. Sabatini follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Refer to
Baltimore MD 21235

FOR RELEASE ONLY UPON DELIVERY

STATEMENT
BY

NELSON J. SABATINI
DEPUTY COMMISSIONER OF SOCIAL SECURITY
FOR MANAGEMENT AND ASSESSMENT

BEFORE THE

SPECIAL COMMITTEE ON AGING
U.S. SENATE

ON

THE FISCAL YEAR 1988 BUDGET AND OLDER AMERICANS

MARCH 13, 1987

Mr. Chairman and Members of the committee:

I am pleased to appear before you today to discuss the Social Security Administration's FY 1988 budget request and how it affects older Americans. I also want to discuss our efforts to improve productivity, service to the public, and public confidence in Social Security.

Socal Security old-age, survivors and disability insurance benefits are funded by a permanent appropriation from the Social Security trust funds. Just a few years ago, the assets of those trust funds were nearly depleted and there were serious doubts about the system's ability to pay benefits.

Fortunately, that situation is history today. Dedication and hard work on the part of the President, the Congress and the National Commission on Social Security Reform culminated in 1983 in the enactment of major reforms to restore the financial stability of the old-age, survivors and disability insurance trust funds. Moreover, economic performance since 1983 has been even better than expected at that time and has further improved the financial status of the program. As a result, according to the 1986 report of the Board of Trustees of the old-age, survivors and disability insurance trust funds, the assets of the funds are sufficient to pay benefits on time for many years into the future even based on our most pessimistic economic and demographic assumptions.

The FY 1988 President's budget reflects a 3.5-percent cost-of-living increase next January in Social Security and supplemental security income benefits to the almost 38 million Social Security and 4 million supplemental security income (SSI) recipients. Also, as you know, the 3-percent cost-of-living trigger in prior law was removed last fall and a 1.3-percent cost-of-living increase was paid in January of this year.

SSA Priorities

Mr. Chairman, in regard to SSA's staffing and service to the public, let me note at the outset that we are committed to the goal of maintaining SSA's reputation of providing high-quality service. At the same time, in our effort to maintain the integrity of the Social Security trust funds, it is incumbent on the Social Security Administration to reduce administrative costs of the program. We know this is a big order and realize it can be accomplished only through sound overall management. Therefore, Commissioner Hardy has established a set of priorities to focus and direct SSA resources and energy. They are:

- Maintaining the fiscal integrity of the Social Security programs.

- Providing the best service to the public.
- Improving the way we manage our programs, to carry them out with greater efficiency, effectiveness and accountability.
- Using the best and most appropriate technology available to administer our programs.
- Recognizing and supporting the vital role of SSA employees.
- Educating the public and improving public confidence in Social Security.

We believe we will be able to accomplish these priorities under the funding levels provided in the FY 1988 budget because of improved productivity overall as a result of management improvements and systems modernization.

Improvements In Service Delivery

Now let me mention a number of recent improvements in service levels which indicate that we are making good progress toward accomplishing our priorities.

- Processing time for retirement, survivors and health insurance claims decreased from 23.4 days at the end of fiscal year 1984 to 20.7 days at the end of fiscal year 1986.
- Processing time for SSI aged claims decreased from about 16.3 days at the end of fiscal year 1984 to 10.1 days at the end of fiscal year 1986.
- Computer response time in offices dealing with the public has been reduced to under 3 seconds, providing the public with quicker responses to inquiries.
- Local field offices have been given immediate online access to information in the SSA data files, resulting in the ability to provide more accurate information to the public and to improve the processing of claims and post eligibility workloads.

Mr. Chairman, I would like to note in this regard that a recent GAO client satisfaction study found that about 80 percent of those who have dealt with SSA rate the service as "good to very good." About 90 percent of our clients said that SSA employees were courteous in serving them, and more than half those surveyed rated SSA's service as better than they received from any other government agency.

We are working to increase productivity and service by continuing to improve our procedures and work processes. For example, we have improved the way we select SSI cases for eligibility redeterminations, with the result that we can reduce resources devoted to this workload without adversely affecting SSI payment accuracy and can reduce the number of SSI recipients who are required to undergo a lengthy personal interview every year. We have also expanded the district office final authorization of initial claims. This decreases the number of claims referred to our program service centers and speeds up payment of benefits.

Systems Modernization

Continued systems modernization is perhaps the most significant way we are achieving improvements in productivity and service. SSA's Systems Modernization Plan identified six areas needing modernization. In four of these areas (hardware, data storage, telecommunications and data center management) modernization is substantially complete. In two of the areas (software development and management information) progress has been made although much more work remains to be done.

These systems modernization achievements have resulted in many direct benefits to the public in the form of better service. For example:

o Social Security cards are now issued in 10 days, where it used to take 6 weeks.

o Annual earnings reports are now promptly posted within about 7 months of receipt, where once SSA was nearly 3 years behind in the postings.

o The computer operation to increase beneficiaries' checks where there is additional work experience to credit used to have a 4-year backlog. That backlog has been eliminated and the operation is conducted promptly each year.

Such direct improvements in service are supported by a foundation of many more indirect systems improvements which have increased efficiency, lowered costs, reduced reliance on staff-intensive manual processes and provided SSA with the modern tools it needs to do its job, now and into the future.

Indeed, hardly a month goes by that we do not realize some immediate savings in staff or time from improvements in systems processes. In February, for example, we implemented an expanded capability to generate earnings records without need for manual reviews. This will save an estimated 42 workyears at a minimum each year. Beginning in March the system will have the capability to generate notices in some SSI cases--an improvement which will save an estimated 350 workyears annually. These are two relatively small projects. But at any given time dozens of such projects are proceeding which will permit us to realize substantial cumulative workpower savings.

In February we also began nationwide implementation of our Modernized Claims System (MCS). Putting a new benefit claim into the computer system currently involves four people: the interviewer who completes a paper application form; the clerk who creates a paper-log control; the data reviewer who prepares a coded data entry sheet; and the teletypist who keys the information into the computer system. Under the new MCS, one person--the interviewer--can efficiently put the claim into the computer system using a computer terminal on his or her desk. About 50 field offices each month will be converted to MCS, and by the end of next year all field offices will be operating under the MCS. We expect this new claims process to improve service and reduce staffing requirements. It is through such use of new technology to work "smarter" that we are convinced we can continue to improve service and productivity.

Other Current Initiatives

Mr. Chairman, as you requested, I would like to conclude by providing a brief overview of some of the positive things SSA is now doing to promote public confidence in the system and to improve service to the public.

We are trying to make service more easily available to the public by pursuing the following ideas: scheduling interviews in Social Security offices to reduce waiting times, experimenting with extended office hours to accommodate people who find it inconvenient to conduct business with us during regular working hours, and promoting the use of the telephone as an alternative to walk-in office visits. Further, we are encouraging local managers to share their best operating practices with other managers, as suggested by the General Accounting Office, in order to reduce the disparity in average workload unit times among geographic regions.

We are also working closely with the Advertising Council--a private, nonprofit group supported by American business and advertising interests that conducts national public service advertising campaigns--to develop a Social Security advertising campaign. Our goals are to educate the public--and particularly the young worker--about the Social Security programs and the protection they provide. We want to drive home the message that the Social Security system is currently financially sound and can be relied upon to pay benefits, not only to today's retirees, but also to those in the workforce who are building protection for the future.

In addition, we are developing a more complete statement of earnings and a more realistic estimate of potential retirement, survivors and disability benefits for workers. This would allow workers to gain a much better picture of the benefits they and their families can expect to receive under Social Security. We are undertaking a pilot in 1987 to determine how best to carry out this important public service improvement.

We know there is still a great deal of work needed to achieve our goals, but we believe our plans are well conceived and will succeed in improving public service and increasing productivity. Let me assure you that we will regularly and closely monitor our performance to assure that we maintain high quality public service. We look forward to working with the Congress as we strive to make SSA more effective and efficient in serving the public.

The CHAIRMAN. You're going to reduce the staff by 3,700 people; is that right?

Mr. SABATINI. Yes, sir. The number is approximately 3,700.

The CHAIRMAN. That's in 2 fiscal years?

Mr. SABATINI. That's in fiscal year 1987. The 1988 reduction is somewhat smaller than that. Those reductions reflect the continued progress toward an overall reduction in the size of the Social Security Administration by approximately 17,000 full-time equivalents off the 1984 base year, and concluding in 1990.

The CHAIRMAN. I think it's easy for you to say and hard for us to do. What are we supposed to tell people when they can't get to see somebody?

Mr. SABATINI. Senator, with the 1985 budget submission we announced that we were going to embark upon a reduction in the size of the agency, and that our target was to reduce the overall size of the agency by 17,000 full-time equivalents by 1990. When we announced that plan we also announced that that plan and those reductions would not be taken at the expense of public service, that we were going to proceed on a very cautious path, look at each year on that path as we went through the budget cycles, and that under no circumstances would we allow those reductions to take place at the cost of public service. And the other thing was that we committed that we would not have a reduction in force. No one in the Social Security Administration was going to lose a job. And we are standing by that commitment, Senator.

The CHAIRMAN. Well, I wonder. Have you ever tried to call?

Mr. SABATINI. Have I tried to call?

The CHAIRMAN. Yes.

Mr. SABATINI. Yes, sir. And there is no question that there are some areas in this country where we have significant problems with our telephone service. I would submit, Senator, that that is a function of some of the antiquated hardware that we are using in our telephone systems and not a function of staff reductions. We are——

The CHAIRMAN. Well, you know, if you're going to give the same level of service, almost all of this starts with a telephone call. I've got a problem; I want to find out about it; hope that it could be settled by a telephone call. If it can't be, I guess I can make an appointment, but if I can't get somebody on the telephone I can't do anything.

Now, let me tell you how bad it is. The line was busy on March 9th—that's Monday—calling either of the numbers here, Virginia or D.C. numbers, at 2:25, 2:55, 3:20. And March 10, 12:45, 2:30, 3:30. March 11th, 9:45, 12:00, 4:00 p.m. March 12th, 9:10 a.m., 10:45 a.m., 1:50 p.m.—that's 4 days just recently, this week, and the lines are always busy. Are you telling me that this is a good level of service?

Mr. SABATINI. No, Senator, I'm telling you that we are not happy with the level of service and the quality of our telephone service. And I believe you will see that the 1988 budget has a request in excess of $50 million to start replacing some of that equipment so that we can have more efficient and better equipment. We recognize that there are places where there is not toll-free service available——

The CHAIRMAN. This isn't toll-free. This has nothing to do with toll-free.

Mr. SABATINI. I understand. We are going to expand our toll-free service. We are going to put in better telephone capacity so we don't lose calls, so we don't have busy signals. We are experimenting with recorded messages to answer relatively routine questions and to provide more efficiency. We have two experiments where the results are very positive on that, and we are, over a 5-year period, going to be replacing the telephone systems in virtually every office in our country so that it reflects the kind of state-of-the-art equipment that will allow us to eliminate these problems that you're describing.

The CHAIRMAN. Deputy, I use a telephone, have for years. The telephone service under whatever system you're using, I'm sure, is no different than the equipment I've used and am familiar with, and that is not the right kind of an answer. You don't have enough people to answer that telephone; that's my strong feeling. And I don't know how you can cut down on people without reducing service; you know, everybody likes to say, well, let's cut back on the number of Federal jobs. But it's obvious that you're not handling these calls and not providing the service. No amount of rhetoric is going to change that situation when you don't have the people there.

I'm not going to dwell on it. I'm just going to tell you that you've put us in a hard spot, because we know that this service is not adequate now, and I don't want to explain to anybody why it even gets worse. This recorded stuff—have you had any testing of that, market testing?

Mr. SABATINI. Yes, we have. We are in the process of piloting that in at least two locations. And it's not a total answer, but there is a significant volume of telephone calls that come to the Social Security offices that ask for routine information, such as, how do I go about getting a Social Security card? How much am I allowed to earn and still collect my benefits? Many of those inquiries can be answered through a recorded message, and we're finding our pilot results to be very successful.

Now, those recorded messages do give the person the opportunity to leave their name and phone number if they want additional information.

I would also like to say that a recent GAO report that did a client satisfaction survey indicated that approximately 80 percent of the people that have had any contact with the Social Security Administration feel that the level of service that they got was rated either good or very good. A more recent GAO report that was issued earlier this week indicates that an assessment of all indicators of our level of services showed that services and quality of our products are as good as, or better than, they've ever been.

Now, we're not satisfied. They're not good enough; they need to be made better. But we can make our service better, through efficiencies. And the problem, again, is with telephones and particularly the telephone service in our metropolitan teleservice center, which services the Washington, DC, area. There are, in large part, hardware problems that we're trying to deal with, and the budget reflects our commitment to deal with those.

The CHAIRMAN. Why are some numbers not even listed?

Mr. SABATINI. Some numbers of local offices are not listed because we have large metropolitanwide—or in some cases, Statewide—telephone answering services that we use to funnel all telephone calls into that center, and then depending on the issue, we can transfer them to other locations. The bulk of the calls that come into that center can be answered directly in that center.

The CHAIRMAN. The Office of Appeals here in Virginia isn't even listed. You can't find the number.

Mr. SABATINI. The Office of Hearings and Appeals in Virginia may not be listed. It may—OK, I'll accept the fact that it's not listed——

The CHAIRMAN. I don't mean that it's for Virginia; I mean that it's for any State. And it happens to be in Virginia.

Mr. SABATINI. That's right; that's a headquarters office that is primarily a staff component where there is little or no day-to-day public business conducted in their offices.

The CHAIRMAN. And why can't lawyers handling cases find that number?

Mr. SABATINI. Based on what I've seen of our litigation workload, lawyers seem to be able to find it quite well. But I will look at the Virginia phone book and find out why it's not there, and we'll get back to you.

The CHAIRMAN. You'd better get back today because I'm going to pass it on. I've got a constituent asking me what that number is, and I'm asking you because it's not listed, and it's impossible to communicate with them except by letter. Now, if that's efficiency, I'll eat my hat.

Mr. SABATINI. I will find out why it's not listed, and we'll find out immediately what the telephone number is and see to it that you have it.

The CHAIRMAN. And advise local offices out in these States what that number is because you can't get it from the State offices. No way of getting it. They don't know; it isn't listed in the directory. All you can do is write a letter and get a response, maybe, in 2 months.

Mr. SABATINI. I will find out what the telephone number is and why it isn't listed, and see to it that our local offices know what it is.

The CHAIRMAN. You know, Deputy, you mentioned efficiency. I'm telling you that this is the height of inefficiency for me to be having to ask you, a Deputy Commissioner about this matter. I've got a constituent who says there is no number for it. Now, having a secret number is a crazy idea, and certainly it doesn't lead to any kind of efficiency. Before we leave here, I'd like to have that number.

You're going to have some automation, and that's part of why you built up a case of justifying the staff cuts. I assume that a lot of this is computer, this modernization and efficiency, is it not?

Mr. SABATINI. Yes, sir.

The CHAIRMAN. All right. When will the software standards be written and the software fully tested?

Mr. SABATINI. The software standards, or at least a set of rules by which the software will have to be written, has been established. Much of the software for the modernization of our claims process has been written and much of it is operational. There are additional releases and improvements to that software that are scheduled over the next several years.

With regard to the post-entitlement part of our workload, we are in the process of developing and moving toward the modernization of that aspect. The schedule now calls for the development of functional requirements for the post-entitlement section of this system to be completed by late summer of this year. Once those functional requirements are established and defined, then the actual software strategy and the schedule for those software releases will be established.

The CHAIRMAN. Well, I guess the GAO has concluded that this systems modernization program is years behind schedule. You're going to reduce the staff before you've got this modernization program——

Mr. SABATINI. I think there are a couple of points. One, the reductions in the staff that have taken place in 1984, 1985, 1986, and 1987 were consistent with the overall reduction plan that we had established. In each of those years, the reductions that we were going to be making were not contingent upon the systems modernization efforts. The modernization efforts would start to yield significant staff savings beginning in 1988, and that's reflected in this year's budget. The only staff savings that would be coming from systems modernization, in the original plan and in the budget, are those savings that were going to be coming from the modernized claims process. The reduction does not reflect anticipated savings for other parts of the plan that are not fully developed and will not be fully in place by 1988.

In addition, the GAO has indicated that some portions of our systems modification effort are behind schedule. That's true, but what the GAO report does not say is that there are some aspects of the modernization effort that were ahead of schedule and that we have, in some parts of the systems modernization plan, made remarkable progress.

At the close of the last fiscal year the agency was approximately 8 percent smaller than it was 5 years earlier; but every measurable indicator that's available, that had been evaluated by us and by the GAO, shows that the level of service, the quality of our product, and the status of our workloads are in better shape than most of us who have been with Social Security can ever remember.

The CHAIRMAN. Well, when you get the software and you get this ready to go, can you assure us that the system will be fully tested before the first stage is implemented?

Mr. SABATINI. Yes, sir. One of the key elements of the overall systems modernization plan, Senator, was to install some management discipline in our system development activity to make sure, absolutely sure, that we had quality control mechanisms in place over our software, that software was fully validated and tested. As we start implementing, and as we have been implementing the modernized claims process, we run that process on a parallel basis before we go live; not only initially, but with every subsequent release to make sure that it's fully tested and that it does work. And I think our efforts are paying off. From 1980 to 1982, there was a 4-

year backlog of unposted earnings in the Social Security Administration. People who had benefit increases due to them because of additional work activity after retirement were not getting them on a timely basis. Today they are. We are current and we are processing that work in a shorter and shorter time frame every year. In 1981 and 1982 it took approximately 6 weeks to get a Social Security card. Today, people are getting Social Security cards in 11 days. Much of that progress and improvement is in direct relationship to our system modernization efforts, so there are good things that have happened with systems modernization, and I think it's important that the record reflect that as well as the criticisms.

The CHAIRMAN. Well, I talked about the General Accounting Office report[3]—and you mentioned in your statement, as a matter of fact, that the General Accounting Office said that 80 percent of Social Security beneficiaries rated the quality of service as good to very good. That's a pretty fair response.

Mr. SABATINI. And I appreciate you mentioning that GAO report for the record, sir, because for some reason that rarely gets into the record.

The CHAIRMAN. Well, we're making it a part of the record just by talking about it.

Mr. SABATINI. One of the recommendations of the GAO in that report was that we continue on an ongoing basis to conduct these types of client satisfaction surveys. We have agreed with that recommendation. We have also decided that to make absolutely sure that we can assure the integrity of the information, we will have these surveys and analyses performed by an independent contractor we will be procuring the service so that we can collect that data and report it and act on it on an ongoing basis.

The CHAIRMAN. Well, that was evidently before we got all these busy signals this week. So you've got an ongoing task.

Mr. SABATINI. Yes, sir.

But, Senator, I would also like to submit for the record a report issued by GAO—I believe on Wednesday—that indicates that the levels of service are as good as or better than they have ever been. And they looked very closely at things like waiting time and quality.

[The following is the Executive Summary of this GAO report. The entire report, less its Executive Summary is printed as Item 3 in the appendix on page 304.]

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[3] See appendix, p. 304.

Executive Summary

Purpose

In January 1985, the administration announced its intention to reduce Social Security Administration (SSA) staff by 17,000, or 21 percent, through fiscal year 1990. Because such cuts could adversely affect SSA service, the House Appropriations Committee asked SSA to report quarterly on its service levels.

In the summer of 1986—because of concerns expressed about the objectivity of SSA's self-evaluation—the Senate and House Appropriations Committees asked GAO to report on SSA service. This is the first of three reports to be prepared for the Committees in 1987.

This report examines: (1) the quality of SSA service, (2) the effect of staff reductions on service, and (3) the nature and extent of past and planned staff reductions.

Background

The terms "service" and "quality" are broad and mean different things to different people. For this reason, GAO examined SSA quality of service from a number of different perspectives.

First, GAO examined the data SSA regularly accumulates to measure performance. These data show how accurately SSA pays and processes claims; how long it takes to process initial claims and appeals of SSA decisions; the amount of work waiting to be processed; and how long clients wait in SSA field offices before being served.

GAO also surveyed SSA clients, managers, and employees. SSA clients were asked their opinions on the quality of SSA service. SSA employees and mid-level managers were questioned about the quality of SSA service and the effect of staff reductions.

To determine whether there was any indication that staff reductions have had a significant adverse effect on service quality, GAO also visited 15 SSA district and branch offices that experienced an average 25-percent reduction in staff over the last 3 years. At these offices, GAO obtained employees' perspectives and reviewed data on processing times and workloads.

To identify the extent of actual staff reductions, GAO determined where the reductions took place and the types of positions affected. GAO also examined SSA plans for carrying out staff reductions for fiscal year 1987.

Results in Brief

SSA's traditional performance measures through December 1986 generally show stable performance since fiscal year 1984—the year before the start of the staff reduction program. Similarly, about 80 percent of SSA clients GAO surveyed said that overall the quality of SSA service was good.

Most SSA employees and SSA managers said service or performance was good, but most in both groups said staff reductions have had an adverse effect on operations. In the 15 offices GAO visited, the data analyzed generally indicated service levels comparable to the levels provided by all SSA offices nationally, with one exception—a significant increase in mean processing time for claims for Supplemental Security Income for the blind and disabled. The increase however does not appear to be related to field office staff reductions.

Concerning staff reductions, in fiscal year 1987—because of reductions in its budget—SSA is planning to reduce work-year use significantly below the levels suggested by the Congress. Overall, the 6 year staff reduction program is on schedule.

Principal Findings

Traditional Performance Indicators Generally Show Stability

Accuracy rates have generally remained stable since fiscal year 1984, according to SSA data. Payment accuracy for the Retirement and Survivors Insurance program, for example, was 99.5 percent of the total dollars paid in fiscal years 1984 and 1985 and increased to 99.6 percent in fiscal year 1986.

Processing time for initial claims and appeals have generally improved, except for disability-related claims. Times for disability claims have increased because of the additional time required by state disability agencies to implement 1984 legislative changes for mental impairment cases.

With few exceptions, nationally the backlogs for SSA's major workloads are down substantially from 1984 levels.

According to SSA, the average time claimants wait in SSA field offices before being interviewed declined steadily from the January-March 1986 quarter through the December 1986 quarter—from a reported 12.3

to 7.2 minutes. GAO, however, believes that wait times are understated because not all waiting time is measured and some field offices give special attention to reducing wait times when they are measured for study purposes. (See ch. 2)

SSA Clients View Service as Good

The preliminary results of a November 1986 GAO survey show that about 80 percent of SSA clients view SSA service overall as good to very good. These results are comparable to the results of an identical survey done by GAO in 1984. (See ch. 3)

SSA Personnel Say Service Good but Reductions Are Having Adverse Effect

About 88 percent of managers GAO surveyed in 1986 said that the performance of their units had improved or was comparable to service levels 3 years earlier. Similarly, 87 percent of employees said that service was the same or better than it was 3 years earlier.

For those who said their units lost staff (55 percent of employees and 66 percent of managers), most said the staff reductions have caused problems. Fifty-six percent of these employees said that staff reductions have had a negative effect on the ability of their units to produce quality work, citing in particular lower morale and increased stress. For the managers who lost staff, 71 percent said the reductions had a negative effect on their operations, citing in general decreased quality of work and decreased productivity. Further, 64 percent of all managers said they were understaffed. (See ch. 3)

15 Field Offices—Service Deterioration in One Aspect Noted

For the 15 field offices, GAO examined data on processing time for four types of benefit claims and data on pending workloads. GAO found significant deterioration in service for the time to process Supplemental Security Income claims for the blind and disabled, which on average increased about 23 days—from 74 to 97 days. For all offices nationally, the increase in time for these claims was only 4 days. The principal reason for the larger increase in the 15 field offices is the relatively higher processing times of two state disability agencies (New York and New Jersey) which make medical determinations for 5 of the 15 offices. (See ch. 4)

Nature and Extent of Past Reductions

Since fiscal year 1984, SSA reduced its total work-year use about 8 percent. Staff reductions were largest in the Office of Disability Operations (14 percent) and the Program Service Centers (13 percent). In SSA field offices, data review technicians were reduced the most—about 23 percent.

From fiscal year 1984 through fiscal year 1986, SSA field office staffing declined 3.3 percent. While 58 percent of SSA's approximately 1,300 field offices had a net loss of staff for the period, 28 percent had a net staff gain, and 14 percent did not have any change. Most offices losing staff through fiscal year 1986 lost less than 10 percent of their staff. (See ch. 5)

SSA Increasing 1987 Staff Reductions

Because of budgetary shortfalls totaling $284 million, SSA plans to significantly reduce its fiscal year 1987 work-year use by about 5,300 below the 78,580 suggested by the Congress. SSA has stated, however, that it will monitor service closely and increase work-year use if necessary. (See ch. 5)

Staff Reduction on Schedule

SSA's proposed fiscal year 1988 budget would reduce staffing by an additional 2,454 full-time equivalent positions. Such reduction would bring the total for the first 4 years of the 6-year staff reduction program to 10,606, or 13.3 percent below 1984 levels, and put the reduction on schedule through the first 4 years.

Recommendations

GAO is making no recommendations.

Agency Comments

Concerning waiting time in field offices, SSA acknowledged that reported times were understated, and said it plans to monitor the time not measured on an ad-hoc basis and will emphasize to field offices that reported data must be representative of normal practices.

The **Chairman**. Well, a GAO report submitted Wednesday means they were looked at about 6 months or so ago. I'm talking about this week, and I'm talking about in relationship to reducing the staff. I think you've got a hard time assuring us that there's going to be good service by this next reduction in staff, if you should get them.

But in that same GAO report that I just cited here, where 80 percent of Social Security beneficiaries rated the quality of service good or very good—80 percent said that——

Mr. **Sabatini**. I said earlier, Senator, we're not happy with that. Eighty percent is a B; we want A-plus.

The **Chairman**. But in that same report, those people that are trying to deal with you on disability and SSI benefit applications, they don't see it that good. And that gets back to that other point I'm making to you. I think you've got a real serious problem with disability and SSI, and I don't think you're on top of it at all. Certainly that example I gave, where the phone number is a secret, is a very good demonstration of how bad the problem is.

Mr. **Sabatini**. Well, I would agree that there was a very serious problem with the disability program. I think that the legislation enacted by the Congress was a positive step toward the resolution of that. In the process of implementing that legislation we are being very careful to implement not only the letter of the legislation, but also the intent and the spirit of the legislation. We are committed to making sure that the disability program is a program that has integrity, does not have people on the rolls that should not be on the rolls, but at the same time making sure that no one is taken off the rolls who should not be taken off the rolls, that people's rights are protected, and that the process is handled in a very humane fashion. I think that with the cooperation and support that we got from the Congress in enacting the disability reform legislation, that the disability program will be under control and that it's going to be a good program and a well-run program.

The **Chairman**. It is not at this stage, and the backlog of these cases just drives these people batty. I think it's one of the most cruel systems we've got. I would tell anyone on disability appeals or disability applications that if they get turned down, to go the appeal route; and if they aren't successful in the appeal, to ask for the next step. I think you've got a horrible system out there—that you can't realize how bad it is unless you go and talk to those people who are handling these cases, and they are continually behind. There aren't enough attorneys to handle everybody's case, and they're delayed, and the process is so lengthy and quite often arbitrary. I think you're costing Social Security an awful lot of money because when they finally do win them, of course, they're going to get the back pay they're entitled to, and the benefits they're entitled to. I think you've got a system, Deputy, that needs to be overhauled. I think it's a very cruel system now, and isn't worthy of our Government.

The law is clear enough, but the delay in getting the final solutions are horrendous. Too many of the Administrative Law Judges are out there simply to keep people off of disability. That's a terrible indictment of their function. I think you'd better investigate it.

Mr. **Sabatini**. Yes, sir.

The Chairman. How would you propose to do it?

Mr. Sabatini. Well, this is the first I've heard that Administrative Law Judges are there to keep people off of disability. I think that the appeal rights that we afford disabled individuals are probably the model of what an appeals process ought to be in many respects. And the fact of the matter is that we have been proceeding very, very carefully and very prudently on the implementation of the congressionally directed mandate that we review the condition of individuals who are on the rolls, making absolutely sure that any decisions to take a person off the roll is thoroughly documented and fully supportable. We've instituted some processes that will offer front-end interviewing so that people who are going to be examined know and understand exactly what the process is, and also we work very hard to make sure they understand what their rights are, Senator.

One of the difficulties with the program is that I think among some part of the American public it's a misunderstood program. The definition of disability for our program is a very stringent definition of disability, and that's set forth in the statute. It talks in terms of a total disability that will last for at least a period of 1 year. That's a very stringent definition of disability.

The Chairman. Well, I'm well aware of that. I'm well aware of the 1 year, but what would you say about somebody that has an IQ of 66; is he supposed to get a job? Where does he find these jobs?

Mr. Sabatini. I don't know that we've arbitrarily denied someone with an IQ of 66. I don't know. If you're referring to a specific case, I'd be happy to look at that.

The Chairman. I'm speaking of a specific category of people whose IQ'~~s are~~ below 70——

Mr. Sabatini. We have nothing in any of our operating procedures or in our regulations that says that a person who has an IQ of 70 or 66 is, per se, not eligible for disability, sir.

Senator, I have just been informed that, for the Office of Hearings and Appeals, the number is 235-8333. I am told that it is listed under the Social Security Administration in the Federal Yellow Pages of the D.C. phone book.

The Chairman. If the number isn't available by operator, then that leads me to believe that I'm not at the right office.

Mr. Sabatini. I don't know. We will look at that. As I say, that's the number and we got it from the Federal Yellow Pages of the D.C. phone book under the Social Security Administration.

The Chairman. I hope we reach a conclusion about this because the number is not available and is unlisted. I can't believe that the information operators repeatedly gave us the wrong answer.

Mr. Sabatini. I will find out. It certainly doesn't make sense to have it unlisted with the operator when it's in the phone book, and we will try to correct that this afternoon.

The Chairman. All right. Thank you very much, Mr. Sabatini. I will be submitting follow-up written questions to you following the conclusion of this hearing.

[The questions and the answers thereto follow:]

JOHN MELCHER, MONTANA, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

March 27, 1987

Mr. Nelson J. Sabatini
Deputy Commissioner of Social Security
for Management and Assessment
Social Security Administration
Altmeyer Building
Baltimore, Maryland 21207

Dear Mr. Sabatini:

Thank you for appearing before the Senate Special Committee on Aging on March 13 and answering questions regarding the impact of the Administration's proposed budget for fiscal year 1988 on Federal agencies providing services to older Americans. Your testimony was helpful and we appreciated having the benefit of your views.

During the course of the hearing, you and other Administration witnesses indicated that you would be willing to answer additional questions that Committee members did not have the opportunity to pose. Keeping your offer in mind, we request that you answer the following questions:

1. It is our understanding that SSA proposes to reduce staff by 2,454 in fiscal year 1988 in addition to the 3,695 reduction already taking place in fiscal years 1986 and 1987. This is in line with the Administration's proposal in 1985 to eliminate 17,000 staff, or 21 percent, in five years through fiscal year 1990. Since then, Congress, through tax reform and the new immigration law, has required SSA to verify Social Security numbers to aid employers in complying with the immigration law and to have all children over the age of five apply for Social Security numbers. However, the SSA has not modified its staff reduction plan. How many staff persons will be required to comply with the Immigration Act amendments alone, that is:

   a. To verify Social Security account numbers being used?

   b. To correct postings of wages to other accounts?

   c. To assist IRS in obtaining retroactive household compliance with payment of FICA and to properly post such taxes to wage records of either illegal aliens or newly legalized aliens?

   d. To issue Social Security account numbers to newly legalized aliens and their spouses and dependents?

2. Recently, SSA reduced the length of time it took to post new earnings and recalculate benefits from 36 months to 18 months. Now SSA claims to have reduced the processing time to seven months. SSA processes overpayments faster, however, than it recalculates benefits even though both were based on the same earnings.

   a. Are overpayments still recovered more quickly than new benefits are recalculated?

   b. Why can't SSA process both underpayments and overpayments within the same time frame?

3. Despite the staffing cuts and additional responsibilities, SSA insists that the quality of service has not and will not suffer. Given those representations, is it safe to assume that SSA would support the passage of a legally enforceable bill of rights for Social Security beneficiaries and contributors? If no, why not?

4. As you know, on November 10, the President signed into law an amendment to the Social Security Act that would make permanent the existing temporary Section 1619. This permits disabled persons, including those who are mentally disabled, to enter the paid labor force without the fear of losing their Medicaid and SSI benefits should they be unable to make a smooth transition from this assistance to self-sufficiency.

   a. Since only 7,000 of the 2.3 million working aged SSI recipients were taking advantage of this protection when it changed from temporary to permanent status, what will your office do to increase the number of disabled persons who are meaningfully employed?

   b. What training initiatives will you undertake in this regard?

5. The Committee believes that knowledgeable attorneys should be available to assist disabled people with the complexities of the system. It is our understanding that just before she left, Acting Commissioner McSteen had for review an SSA draft proposal that would have greatly simplified the process and standards for paying attorneys fees.

   a. What happened to this SSA proposal?

b. We are told that SSA/Office of Hearings and Appeals has been changing the rules on attorneys fees. Is that correct?

c. Please supply the Committee with copies of all issuances on attorneys fees in the last year. This should include all guidance to ALJs and SSA staff, regardless of whether it was published for notice and comment.

6. In 1984, Congress required SSA to initiate demonstration projects in which disabled individuals would meet face-to-face with the State DDS disability adjudicator before a decision is made at the initial level, both in application and termination cases.

a. How have the budgetary cuts affected these projects?

b. Please supply the Committee with copies of all materials establishing the projects and explaining how they are being conducted.

The Aging Committee is keeping the hearing record open and will be placing our follow-up questions and your answers in our print of the hearing's proceedings. It is our intention to submit these additions to the record by April 17, 1987. Therefore, we request that you relay your answers to the above questions prior to that date.

Your continued cooperation in this matter is appreciated and we look forward to your responses.

Sincerely,

John Melcher
Chairman

John Heinz
Ranking Minority Member

Answers to Questions from the
Senate Special Committee on Aging

1. It is our understanding that SSA proposes to reduce staff by 2,454 in fiscal year 1988 in addition to the 3,695 reduction already taking place in fiscal years 1986 and 1987. This is in line with the Administration's proposal in 1985 to eliminate 17,000 staff, or 21 percent, in 5 years through fiscal year 1990. Since then, Congress, through tax reform and the new immigration law, has required SSA to verify Social Security numbers to aid employers in complying with the immigration law and to have all children over the age of 5 apply for Social Security numbers. However, the SSA has not modified its staff reduction plan. How many staff persons will be required to comply with the Immigration Act amendments alone, that is:

   a. To verify Social Security account numbers being used?

   b. To correct postings of wages to other accounts?

   c. To assist IRS in obtaining retroactive household compliance with payment of FICA and to properly post such taxes to wage records of either illegal aliens or newly legalized aliens?

   d. To issue Social Security account numbers to newly legalized aliens and their spouses and dependents?

1. The current budget request for FY 1988 is based on estimated workloads, and savings expected from planned management, procedural and systems changes. The FY 1988 agency work year estimate incorporates the anticipated increased Social Security number workloads resulting from the Tax Reform Act of 1986 and the Immigration Reform and Control Act of 1986. For budget purposes, we have assumed that most of the tax related work will be done in FY 1988.

   Preliminary estimates show that about 2,500 workyears may be required to process the additional enumeration work resulting from the Tax Reform and Immigration Reform legislation. We also expect that immigration reform may produce an increased number of earnings discrepancies to be resolved, although we have no estimates at this time of the magnitude of this potential workload. As we gain experience with implementation of this legislation SSA will be in a better position to assess the impact of these activities on our workload and resource requirements.

2. Recently, SSA reduced the length of time it took to post new earnings and recalculate benefits from 36 months to 18 months. Now SSA claims to have reduced the processing time to 7 months. SSA processes overpayments faster, however, than it recalculates benefits even though both were based on the same earnings.

    a. Are overpayments still recovered more quickly than new benefits are recalculated?

    b. Why can't SSA process both underpayments and overpayments within the same time frame?

2. Over the past several years, as we have posted earnings at earlier points in time, we have simultaneously accelerated both our earnings enforcement overpayment detection operations and our Automatic Earnings Reappraisal Operation for recomputing benefits. This year, the enforcement operations (based on 1985 earnings) were completed in January 1987, and the 1985 earnings recomputation operations were completed in March 1987. The 2-month span between the operations has existed for several years now. We plan to conduct the enforcement operation for 1986 earnings in the October-November 1987 period and the recomputation operation in January 1988.

    Enforcement operations are conducted before recomputation processing as a matter of policy. We believe that it would be a poor business practice to increase benefits based on earnings and then tell some beneficiaries that both the original and increased benefits represented overpayments. While concurrent processing would obviously represent the optimum solution, the state of our current system and software precludes this. The systems processes are separate and require major operations to conduct. The 2- to 3-month time separation is the best that can be achieved in our current environment. Once full modernization is in place, simultaneous enforcement-recomputation processing should be possible.

3. Despite the staffing cuts and additional responsibilities, SSA insists that the quality of service has not and will not suffer. Given those representations, is it safe to assume that SSA would support the passage of a legally enforceable bill of rights for Social Security beneficiaries and contributors? If no, why not?

3. The rights of individuals to benefits and to appeal adverse decisions under the Social Security program are clearly established by law. The Social Security Act provides detailed requirements for entitlement to benefits and for the appeal of adverse determinations made by the Social Security Administration (SSA).

Throughout its 50 year history, SSA has been firmly committed to providing the best possible service to the public in an effective and efficient manner. Recent General Accounting Office reports document that SSA has maintained or improved its service to the public over the last few years, in terms of client satisfaction and performance measurements.

We have not identified a need for any additional guarantees that might be contained in a bill of rights, which are not already fully provided for in existing law, regulations and operating procedures. However, our procedures and operations are being evaluated constantly both internally and by external oversight entities, and we will continue to make every effort to use the valuable feedback gained from these evaluations to maintain and improve our service to the public.

4. As you know, on November 10, the President signed into law an amendment to the Social Security Act that would make permanent the existing temporary section 1619. This permits disabled persons, including those who are mentally disabled, to enter the paid labor force without the fear of losing their Medicaid and SSI benefits should they be unable to make a smooth transition from this assistance to self-sufficiency.

   a. Since only 7,000 of the 2.3 million working aged SSI recipients were taking advantage of this protection when it changed from temporary to permanent status, what will your office do to increase the number of disabled persons who are meaningfully employed?

   b. What training initiatives will you undertake in this regard?

4a. As of December 1986, there were almost 2 million blind or disabled SSI beneficiaries who were between the ages of 18 and 65. As of January 1987, there were 9,000 individuals eligible under the provisions of section 1619. We estimate that approximately 55,000 individuals have, at one time or another since January 1980, been eligible under the provisions.

As required by law, we will tell every adult disabled or blind recipient of potential eligibility for section 1619 protection in the event of work despite condition. This information will be included in the notice of SSI eligibility. In addition, the same information will be given to any disabled or blind individual at the time monthly earnings of $200 or more are reported and periodically thereafter.

In order to increase the numbers of participants under section 1619, we are also mounting a public information campaign at the national and local levels to reach organizations that work with the disabled to let them know that SSI recipients can work without losing their disability status.

SSA's current and ongoing outreach/liaison plans include:

- Meetings at national and regional levels with representatives of groups that provide support and services to disabled and blind people to advise them about pending changes in 1619 provisions and to review existing work incentives.

- Designation of a Work Incentives Liaison in every district office who will be responsible for initiating and maintaining outreach efforts with local advocacy groups and organizations that provide services to disabled and/or blind individuals. Backing up this Work Incentives Liaison is a network of work incentive experts fanning out from central office specialists to a work incentives specialist in each regional office.

- SSA will provide a videotape and training package on work incentives that will be used for training staffs of provider organizations. SSA will also be working with the Office of Education and State Vocational Rehabilitation Agencies (VRAs) to involve local VRAs in joint training sessions and other informational activities with local SSA offices.
- Distribution in late May or early June of a special Public Information Program Circular on work incentives to field offices (FOs) and organizations with special interest in SSA's programs.
- Publication of an article on work incentives in the "Commissioner's Corner" column which is carried in approximately 1,200 newspapers across the country.
- Release to FOs before July 1 of a revised model presentation for use in making speeches on work incentives before interested organizations.
- Revision and updating of the "Redbook"--"A Summary Guide to Social Security and SSI Work Incentives fo the Disabled and Blind" for distribution to State vocational rehabilitation agencies and other service agencies and organizations. This booklet is designed to assist professional workers in the public and private sector who work with disabled people. One hundred thousand copies will be printed.

In addition to these efforts to increase public awareness of section 1619 protection, SSA is also actively using the demonstration authorities provided in the Social Security Act in several initiatives intended to increase the number of SSI recipients who return to work. These are the:

- Vocational Rehabilitation and Employment Demonstrations

  In the spring of 1987, SSA is planning a grant announcement for rehabilitation and employment demonstrations. The objective will be to test innovative approaches to encouraging and assisting SSDI and SSI disabled and blind recipients to return to work. As a first step, on March 10, 1987, SSA published the public inquiry notice requesting public recommendations of priority areas for the spring 1987 grant announcement.

  The March 10, 1987 notice was sent to over 300 organizations, including a variety of networks known to be interested in the disabled and blind.

- Transitional-Employment Training Demonstration

  SSA is presently conducting a demonstration of transitional-employment training for mentally retarded SSI recipients.

  In demonstrating the effectiveness of transitional-employment training, this project incorporates utilization of the protections of SSI payments and Medicaid afforded by section 1619. Initial results will be available in October 1987.

- Project to Improve Communication and Marketing of Work Incentives

  SSA has contracted with Portfolio Associates, a marketing research firm, for development of more effective methods of presenting work incentives and encouraging their use. While this project targets on the Social Security disability (SSDI) beneficiaries, it will also affect the supplemental security income population.

  Portfolio has completed a series of focus group interviews with beneficiaries, physicians, rehabilitation counselors, employers and SSA claims representatives on factors influencing return to work. It also has been reviewing SSA materials (e.g., leaflets) for communicating work incentives. It is about to complete a final round of focus group interviews in preparation for field testing new communication and marketing approaches involving beneficiaries, SSA staff, and rehabilitation providers.

4b. The following initiatives are planned to train SSA staff to implement revised/permanent 1619 provisions effective July 1, 1987. Training will also review existing SSI work incentives and explain how section 1619 provisions interact with title II disability provisions in some instances.

- Creation of a three-level training package for internal training and outreach activities. The first part consists of a videotape and an accompanying lecture/discussion package that will introduce the work incentives provisions and show how they reduce barriers to work. Part two will provide enough information so that participants will know when different work incentives should be considered. The third, and most technical part of the package, will be delivered to SSA staff responsible for adjudication of work incentives. Completion of all three levels of training is designed to produce a high level of expertise in all aspects of the work incentive provisions among all SSA public contact employees.

- National-level training of regional Work Incentive Specialists in May.

- The Work Incentives Liaison in each district office will plan, direct, and conduct work incentives training activities and evaluate the effectiveness of training.

5. The Committee believes that knowledgeable attorneys should be available to assist disabled people with the complexities of the system. It is our understanding that just before she left, Acting Commissioner McSteen had for review an SSA draft proposal that would have greatly simplified the process and standards for paying attorney fees.

   a. What happened to this SSA proposal?

   b. We are told that SSA/Office of Hearings and Appeals has been changing the rules on attorney fees. Is that correct?

   c. Please supply the Committee with copies of all issuances on attorney fees in the last year. This should include all guidance to ALJs and SSA staff, regardless of whether it was published for notice and comment.

5a. Proposals to simplify the process used to evaluate and approve fee petitions of representatives of claimants are being considered as a part of our comprehensive review of the entire attorney fee area. The goal is to speed up the processing of fee petitions, reduce paperwork for claimant's representatives, and reduce administrative costs for SSA.

5b. SSA is not changing the basic rules on the factors we consider in setting an appropriate attorney fee. This would require a change in our regulations and no changes have been proposed. We have made a procedural change in the delegation of authority to our ALJs to set attorney fees. Up until now, an ALJ could authorize a fee of up to $3,000; fees over that amount had to be approved by a Regional Chief ALJ. Under the change we have made, if an ALJ believes that a fee above $1,500 is appropriate, the fee petition and supporting documentation (including the ALJ's recommendation) must be forwarded to the Regional Chief ALJ for fee authorization.

We have made this change as an interim measure in response to a report of the Office of the Inspector General which concluded that SSA ALJs were generally not evaluating fee petitions in accordance with the regulations and have at times permitted the charging of excessive fees to claimants. It was apparent that immediate action was needed to improve our management of the fee approval process and protect the economic security of our beneficiaries. We expect the delegation change will result in more consistent, uniform and equitable fee determinations based on our regulations. At the same time, we will plan and implement, as quickly as possible, steps that will over the long term streamline the attorney fee approval and payment process.

5c. Issuances on attorney fees released during the period March 1986--March 1987 were submitted by SSA and copies of this information can be obtained from the Aging Committee hearing file.

6. In 1984, Congress required SSA to initiate demonstration projects in which disabled individuals would meet face-to-face with the State DDS disability adjudicator before a decision is made at the initial level, both in application and termination cases.

   a. How have the budgetary cuts affected these projects?

   b. Please supply the Committee with copies of all materials establishing the projects and explaining how they are being conducted.

SSA has allocated adequate funds for the participating States to conduct the demonstration projects. We provided funds for increased travel costs and potential increased medical costs associated with the projects. In addition, demonstration project cases involving face-to-face interviews are being double counted toward workyear realization. This means that if the State workload realization exceeds 100 percent with the double count, we will take action to provide additional funds or reduce other workloads.

While workload and funding concerns caused some States to reconsider their prior commitments to participate in the demonstration projects, we were able to substitute other suitable States for those which withdrew participation. Ten States--Arizona, Michigan, Mississippi, New Mexico, Washington, California, Florida, Maine, Missouri, and New Jersey--are actively participating as required by the legislation.

(The Notice of Proposed Rulemaking, the final regulation implementing the project, and the operating instructions used to process demonstration cases were submitted by SSA and copies of this information can be obtained from the Aging Committee hearing file.)

The **Chairman**. Now we're going to hear from two aging advocacy organizations. If you'll both come up to the table at the same time.

Mr. Eugene Lehrmann, American Association of Retired Persons, and Mr. Jacob Clayman, president of the National Council of Senior Citizens.

Mr. Lehrmann?

STATEMENT OF EUGENE LEHRMANN, AMERICAN ASSOCIATION OF RETIRED PERSONS; ACCOMPANIED BY STEPHANIE KENNAN, LEGISLATIVE REPRESENTATIVE

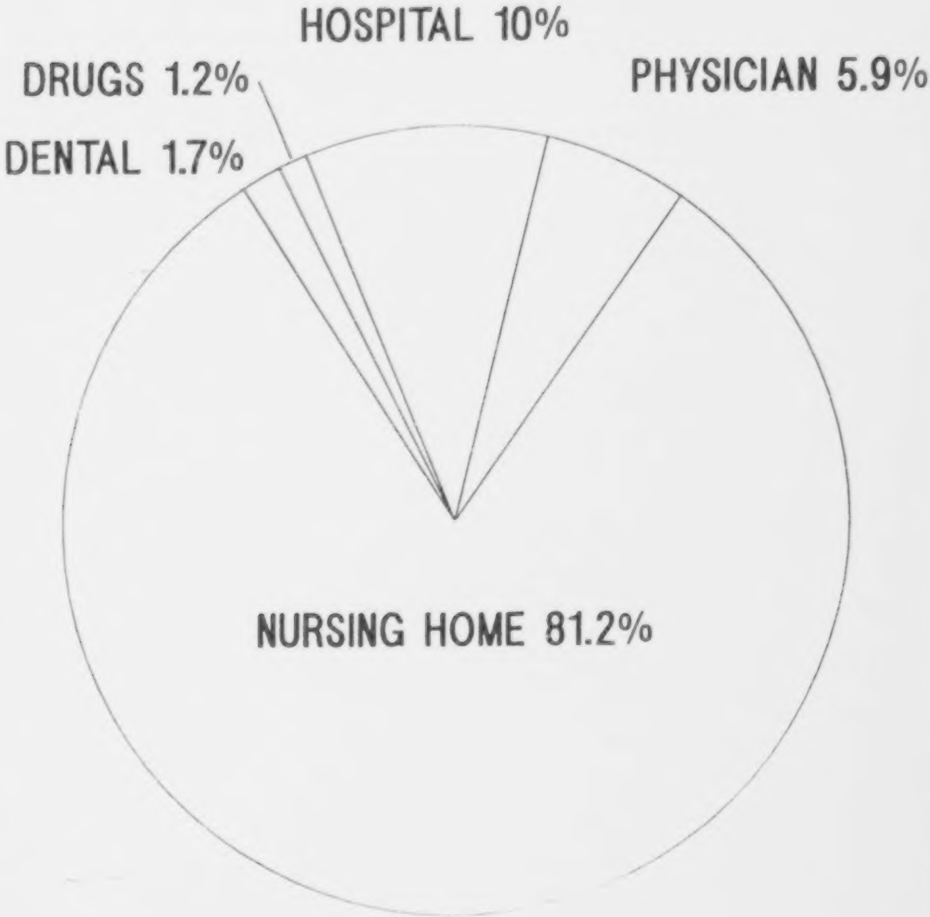
Mr. **Lehrmann**. Good afternoon and thank you, Mr. Chairman. I am Gene Lehrmann, a member of the Board of Directors of the American Association of Retired Persons. The Association, representing the interests of more than 24 million persons age 50 and over, appreciates the opportunity to testify on the impact of the Administration's budget proposal on older Americans.

Older Americans have a major stake in the debate over the deficit and how to reduce it. Our members understand the threat the deficit poses to our Nation's economy, and also do not want to pass on a legacy of debt to their children and grandchildren. While the poverty rate for older Americans has declined, 3.5 million elderly persons are below the poverty line and more than one in five older Americans live on subsistence income within 125 percent of the poverty line.

Mr. Chairman, we share your particular concern about the effect of changes in Medicare on older Americans. Since 1981, Medicare, Medicaid, and other health programs have been reduced by over $30 billion. The Administration's fiscal year 1988 budget proposes an additional cut of $6 billion in Medicare and Medicaid. Medicare already pays for less than half of an elderly person's health bills; yet, the Administration's budget would have older Americans pay an even greater share of health care costs.

I refer you to the chart that we have posted over here on the side. Unless Congress modifies these proposals, the devastating result will be less access to health care for the Nation's elderly and higher out-of-pocket costs for beneficiaries.

Medical Expenses of Elderly With Over $2000 in Annual out-of-pocket costs



Source: Rice and Gabel, *Health Affairs*, Fall, 1986

AARP has serious reservations about suggested cuts in many domestic programs that benefit low income persons of all ages. The proposed elimination of the Section 202 housing program is but one illustration of the impact that the Administration's budget proposals will have on our Nation's most vulnerable population. The Section 202 program is critical because it gives low income elderly and the disabled access to affordable homes especially adapted to their needs. Funding for the program already has plunged by 40 percent since 1979. Long waiting lists for existing projects indicate an unmet need for this specialized housing that will only be exacerbated if Congress cuts the program.

Finally, the Association is concerned about the impact of the proposed reduction of almost 4,000 staff at the Social Security Administration. High quality service has been SSA's hallmark, and we believe it should continue in their mission. Despite SSA's contention that its new computer system will compensate adequately for the reduced staff, beneficiaries complain of a growing lack of responsiveness by agency personnel. The most accessible part of the Social Security system, the local SSA office, could be threatened because there simply would be not enough staff to keep offices open.

The Association has consistently supported deficit reduction efforts that meet the dual tests of fairness and effectiveness. We believe that Congress should adopt a budget that includes revenue increases, restraints in defense, and reductions in the rate of growth of health spending. Also, further cuts in domestic spending should not be achieved through benefit reductions in human services. The Association's members want to see the deficit come down further and are prepared to work to that end in a way that does not inflict an inequitable burden on any one group of Americans.

Mr. Chairman, we will try to answer any questions that you might pose.

The CHAIRMAN. All right. Thank you very much, Mr. Lehrmann.

[The prepared statement of Mr. Lehrmann follows:]

AARP

STATEMENT OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

ON

THE PROPOSED FISCAL YEAR 1988 BUDGET:

WHAT IT MEANS FOR OLDER AMERICANS

BEFORE THE

SPECIAL COMMITTEE ON AGING

United States Senate

March 13, 1987

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

The American Association of Retired Persons (AARP), with more than 24 million members above the age of 50, appreciates the opportunity to comment on the impact of the Administration's FY 1988 budget proposal on older Americans. The Association commends you, Mr. Chairman, for convening this hearing in a timely manner.

AARP supports a fair and effective deficit reduction strategy, one that recognizes past sacrifices and distributes future deficit reduction burdens equitably among all Americans. Our members are vitally concerned about reducing the deficit. They understand the threat the deficit poses to our nation's economic well-being and also do not want to pass on a legacy of debt to their children and grandchildren.

The Association urges lawmakers and the Administration to consider two essential factors in their budget deliberations.

- First, while the elderly poverty rate has declined, one in five older Americans still live on a substinence income -- within 125 percent of the poverty line. As subgroups, minority elderly and older women living alone experience an even higher poverty rate than other older Americans. (See appendix.)
- Second, that escalating health care costs place a significant burden on older Americans, the majority of whom live on fixed income.

An evaluation of the Administration's FY 88 budget suggests that these two factors were not adequately taken into account. Fortunately, in previous years Congress has sought to restore balance to other budget proposals. An analysis of specific proposals impacting the elderly is detailed below.

Medicare and Medicaid Reductions

The Administration's budget relies too heavily on cuts in health care as a way to reduce the federal deficit. The Association acknowledges that since 1981 certain cutbacks in Medicare were necessary to protect the Hospital Insurance trust fund. However, these reductions in Medicare and Medicaid have placed increasing stress on older persons. Cuts made in the name of deficit reduction have in fact had little effect on reducing the deficit but have seriously threatened the elderly's access to health care.

During the next decade, the Medicare population will grow by 18 percent. The number of elderly over age 85 will increase by 50 percent. Massive reductions in health care programs must not be made at a time when the number of older Americans who need these services is increasing.

Medicare already pays for less than half of an elderly person's health bills, yet the Administration's budget would make older people pay an even greater share of health care costs. For example:

- The FY 88 budget increases Part B premiums. Under this particular proposal, three separate premiums would be established for new and current beneficiaries and third party payers. Premiums for current enrollees would be set at 25 percent of program costs. New enrollees would pay 35 percent of the program costs, and the premiums for third party payers would be set at 50 percent of program costs. Beneficiaries who are already paying over 60 percent of Part B physician charges would pay even more under this new tiered system.

- The Administration's budget proposes to reimburse hospital-based radiologists, pathologists and anesthesiologists a prospectively determined fee instead of the standard fee for service. The proposal would allow these physicians, who would not be required to accept assignment, to charge beneficiaries an additional fee.
- The budget proposes to delay eligibility for Medicare. Under current law, eligibility for Medicare begins on the first day of the month in which an individual's 65th birthday occurs. The Administration has proposed delaying eligibility until the first day of the month following the month in which an enrollee's 65th birthday falls.
- The President's budget provides for the expansion of Medicare vouchers. Under this proposal, Medicare beneficiaries would have the option of receiving a

fixed-sum or credit to purchase private health insurance in lieu of Medicare coverage. The current option under which beneficiaries may enroll in HMOs would be expanded to include Preferred Provider Organizations (PPOs). Establishing this voucher system for Medicare beneficiaries could lead to the development of multiple health plans. If this occurs, the national standards, quality safeguards, and appeal mechanisms guaranteed beneficiaries under the current system would disappear.

- For the third year, the Administration's budget proposes to reduce federal Medicaid payments to states by $1 billion in FY 88 and institute a reimbursement cap in subsequent years. States have already drastically cut Medicaid eligibility and services to meet previously enacted reductions in federal matching funds, and these new proposals would further threaten the health and financial security of low income elderly people, particularly frail nursing home residents.
- The FY 88 budget proposes to eliminate states' discretion over Medicaid transfer of assets rules and would require states to review any transfer of assets that occurred up to two years before an individual applies for Medicaid benefits. Current law allows states to set guidelines for transfer of assets and to penalize a person who disposes of assets to gain

Medicaid eligibility. If this discretionary authority is eliminated and states are required to review any transfer of assets before granting Medicaid, this could result in delayed Medicaid eligibility for those individuals most in need of care.

Proposals like those included in the President's budget threaten the quality of care for older Americans. We urge Congress to reject these latest proposals and take a more balanced approach to deficit reduction.

Social Security

Because of the changes in Social Security benefits enacted in 1981 and 1983, the cumulative reduction in benefits between fiscal years 1982 and 1985 was $8.7 billon. By 1990, reductions in 1981 and 1983 are expected to save over $50 billion. These changes were especially damaging to low income elderly, who, at the same time, were also experiencing significant reductions in other federal social programs and in Medicare and Medicaid.

Fortunately, the President's FY 88 budget calls for no reduction in benefits for those receiving Social Security. AARP applauds the President for recognizing that Social Security, funded by dedicated payroll taxes and currently building a reserve, is not contributing to the deficit.

However, the budget proposes reducing the staff at the Social Security Administration (SSA), by almost 4,000 persons. SSA contends its modernized computer system will improve productivity and service and that the net effect of the staff reductions would be imperceptible. However, complaints from recipients indicate a growing lack of responsiveness by agency personnel. Furthermore, a recent General Accounting Office report indicates that the accomplishments of the Claims Modernization Project (CMP) have been limited. For example, the goals of the CMP have been reduced and post entitlement processing programs virtually eliminated. Personnel decreases that result in questionable savings are unwise.

Adequate staffing at SSA is a serious concern, and high quality service has been and should continue to be the mission of SSA. This year's proposed cuts, coupled with previous reductions, would exacerbate existing service problems such as long lines, poorly trained and/or overworked staff, and delays in reaching telephone service centers. Exaggerated claims of efficiency will ultimately lead to lower quality service, and higher incidence of errors and higher costs. In addition, the most accessible part of the Social Security system, the local SSA office, could be endangered because there simply would not be enough staff to keep offices open.

Programs Affecting Low Income Elderly

While some reductions in Social Security and Medicare are probably inevitable given the precarious state of the Old Age, Survivors and Disability Insurance and Hospital Insurance trust funds, reductions in low income programs lack any such rationale. Low income entitlements and discretionary spending programs have been especially battered by a spending assault. A significant portion of older Americans receive benefits from one or more of these important programs. Thus, these elderly recipients have endured a double or triple jab instead of a single devastating blow caused by Medicare and Social Security benefit reductions.

As in the past, this year's proposed budget slates several low income programs for freezes or cutbacks. In some cases, outright elimination has been suggested. The impact of these proposals are detailed below.

1. Housing

Many older Americans receive federal assistance through a number of initiatives. Some fund new housing construction, some help underwrite the cost of shelter, and some are used to renovate existing buildings.

The Section 202 housing program is of particular importance to older Americans. The Administration proposes to eliminate Section 202 housing for the elderly and handicapped by reducing the FY 87 funding level and shifting the reduced funds into FY 88. The program would be terminated once the FY 88 funds are exhausted.

The Section 202 housing program makes loans to non-profit sponsors to construct housing with special features and services that would not be available or affordable to low income older and disabled persons in the marketplace. Such features include lowered countertops, non-slip floors, grab bars, extra wide doorways. These adaptations allow Section 202 residents to maintain the fullest measure of independence and security.

Long waiting lists for existing projects -- and a very low turnover rate in occupancy -- indicate the success of the program and the growing problem of unmet needs for this type of specialized housing. Ending the 202 program would compound the hardships for the population.

The full range of the Administration's housing proposals, too numerous to elaborate in this testimony, have jeopardized the overall availability of low income housing over the last several years. The Administration's ongoing efforts to substitute housing vouchers for existing programs have exacerbated the shortage of low income housing stock. Furthermore, reduced funding for modernization and rehabilitation has forced many persons to live in substandard and decaying homes without any prospect of improvement.

2. Energy Assistance

The Low Income Home Energy Assistance Program (LIHEAP) helps low income households pay home heating and cooling bills. Over a third of all participating households are elderly. The Administration proposes to reduce the Low Income Home Energy Assistance Program from this year's level of $1.85 billon to $1.2 billion. Older persons' heightened vulnerability to weather extremes makes them particularly susceptible to harm from reduced spending.

3. Nutrition

The adequacy of older Americans' diets is ensured through several programs. Food stamps represent a direct purchase subsidy, while other programs provide meals to older persons directly.

The Administration proposes reducing the food stamp allotment for households that also receive energy assistance. Since older persons represent a disproportionate share of households with LIHEAP assistance, they would be especially hard hit by such a proposal. Also, the increased asset limit, which makes it easier for low income elderly single persons-- especially older women living alone -- to receive benefits, would be repealed. In addition, more severe food stamp error rate sanctions would be levied on the states, causing a larger drain on state revenues and endangering state support of other low income programs, such as Supplementary Security Income (SSI).

Other nutrition programs serving the elderly would also be cut back. Title III Congregate and Home-Delivered Meals would be frozen at pre-sequestered FY 86 levels. The Administration would also change the Nutrition Program for the Elderly to a formula grant rather than a program on a per meal basis

4. Social Services

A range of social service programs enable all low income people to receive essential services that link them to their community. A reduction, or, even worse, an elimination of such services could result in greater social and economic costs than if these services were maintained at present levels. In the case of low income older persons, the absence of such services could lead to premature and unnecessary institutionalization.

The FY 88 budget proposes to lump together 26 federally-funded social programs into a generic appropriation of $2.2 billion. The Office of Human Development Services would decide how to allocate the appropriated funds among the programs. Under such circumstances, obtaining increased funding for a specific program would be much more difficult and programs would in essence, become competitors for these federal funds.

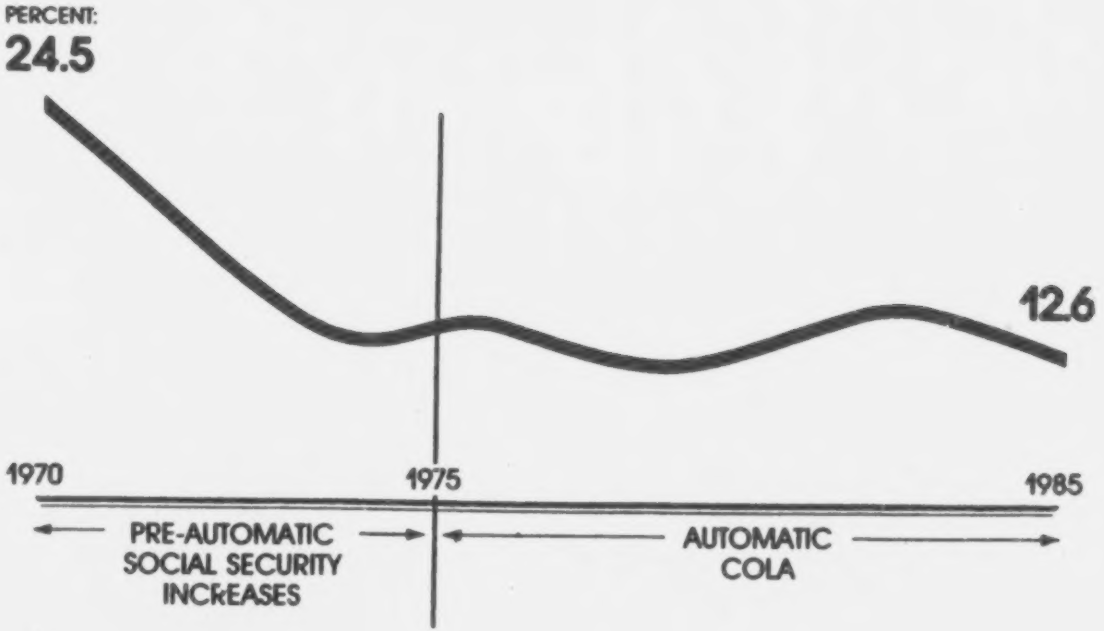
Conclusion

The Association has consistently supported a deficit reduction efforts that meets the dual tests of fairness and effectiveness. AARP urges the Administration and Congress to address the deficit primarily by (1) continuing to apply the same scrutiny to defense spending as has been applied to non-defense spending; (2) restoring the revenue base to a more fiscally prudent level; and (3) reducing the rate of growth in health spending by enacting reforms to slow cost increases for all Americans. In addition, further reductions in domestic spending should not come from benefit reductions in human services.

The Association understands that crafting a budget which meets this year's Gramm-Rudman-Hollings mandated goal of a $108 billion deficit is a Herculean task.

The Association recognizes that adjusting the target to reflect the performance of the economy may be necessary. Some will see any adjustment in the targets as a dangerous precedent, while others will understandably see this as an attempt to unravel Gramm-Rudman's fiscal discipline. That is not our purpose. We continue to support deficit reduction and efforts toward its accomplishment in a way that does not inflict an inequitable burden on any one group of Americans.

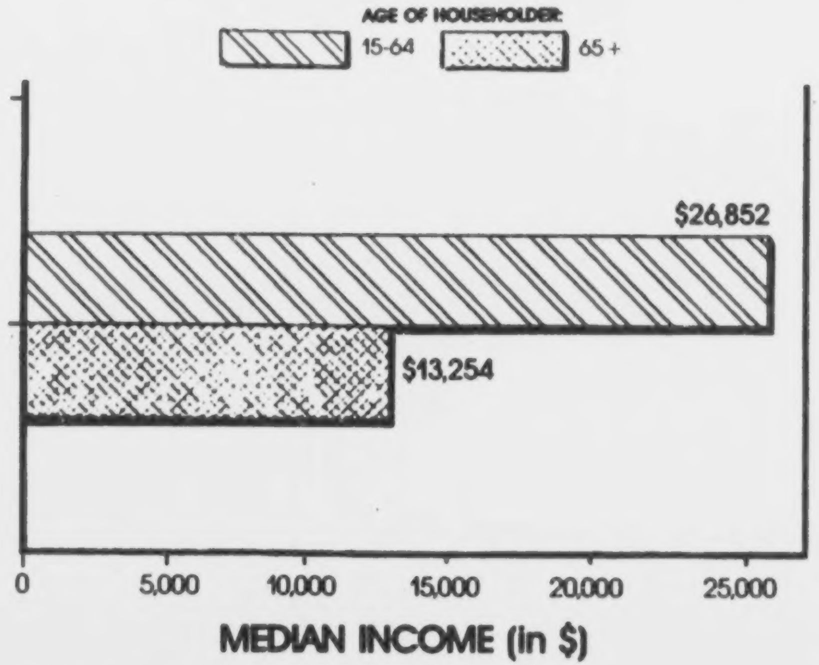
POVERTY RATE
(Age 65+)



Source: U.S. Bureau of the Census, 1985

Chart 2

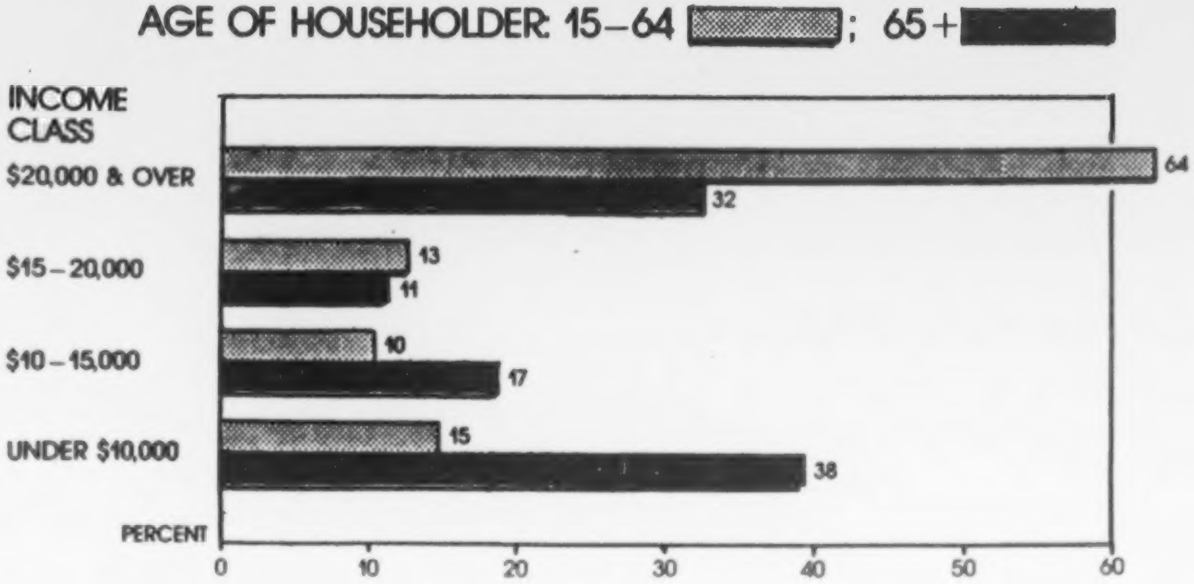
1985 HOUSEHOLD INCOME:
Elderly vs. Non-Elderly



Source: U.S. Bureau of the Census, 1985

Chart 3

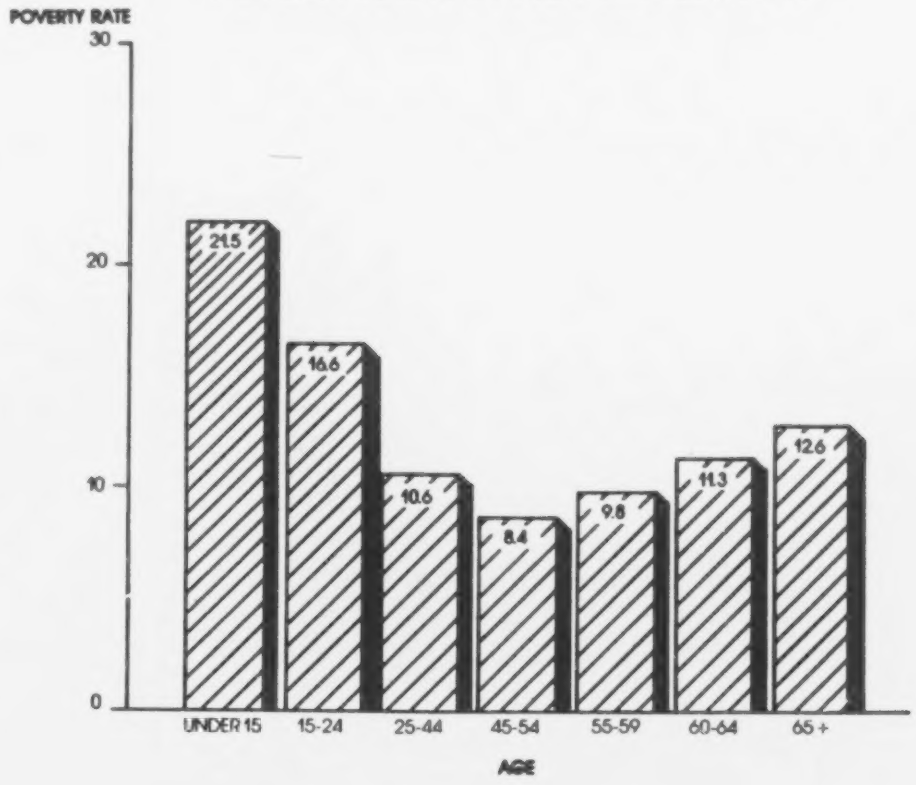
1985 HOUSEHOLD INCOME: Elderly vs. Non-Elderly



Source: U.S. Bureau of the Census, 1985.

Chart 4

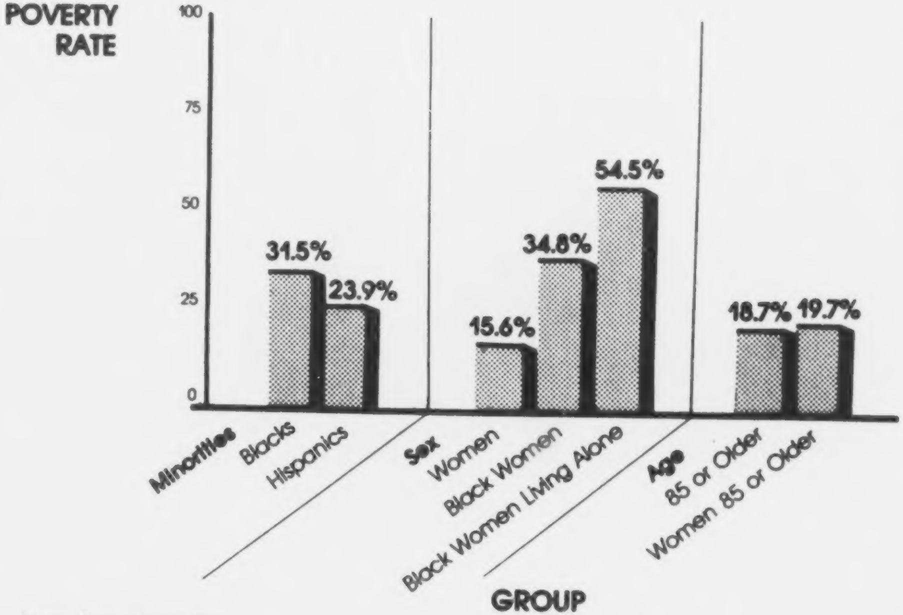
POVERTY RATES BY AGE GROUP, 1985



Source: U.S. Bureau of the Census, 1985

Chart 5

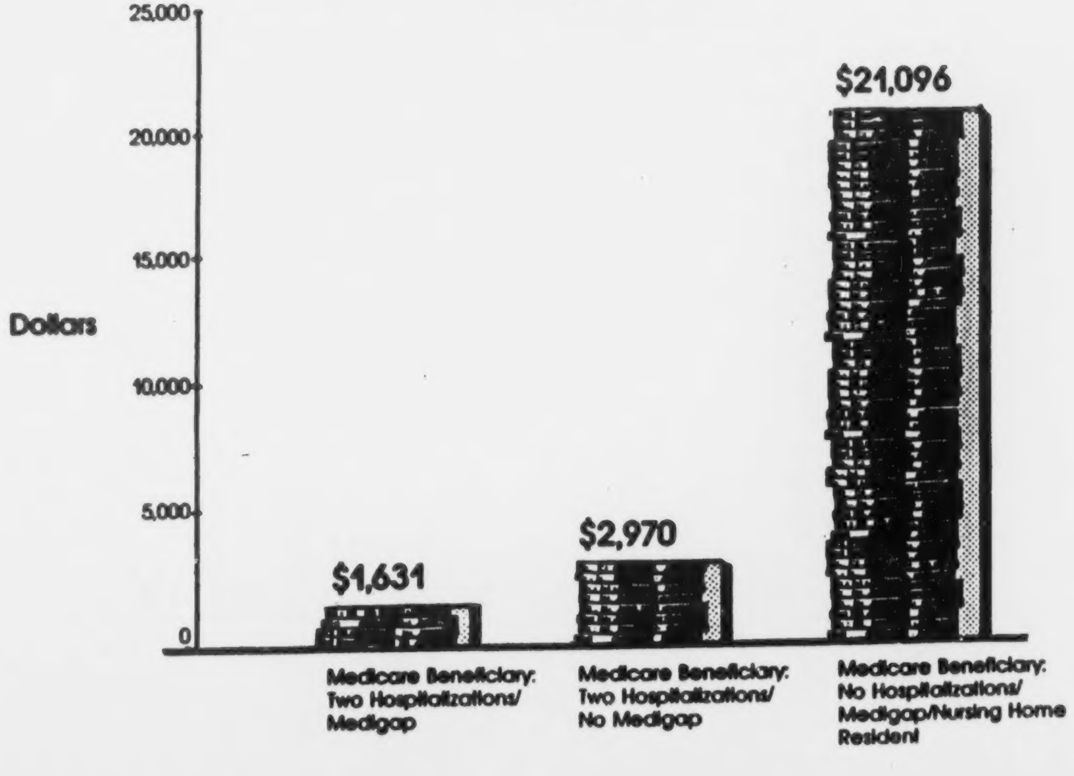
ELDERLY SUBGROUPS WITH HIGH POVERTY RATES



Source: Census Bureau, 1985

Chart 6

ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



The CHAIRMAN. We'll first hear from Jake Clayman and then we'll have some questions.

Jake?

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS; ACCOMPANIED BY ENID KASSNER, SENIOR POLICY ANALYST

Mr. CLAYMAN. Mr. Chairman, first, I have with me one of our associates, Ms. Enid Kassner.

I welcome this opportunity to appear for the first time before your committee since you took over the job of chairman, and I must say that I personally am grateful that events have made this possible.

The CHAIRMAN. It may be the first time, Jake, but it isn't going to be the last time.

Mr. CLAYMAN. Well, I hope not, sir. In any event, we welcome this opportunity to address the impact of the President's proposed budget on our Nation's elderly. In doing so, it is important to view this budget in the historical context of recent budget action.

Over the past 6 years our Nation has witnessed a fundamental shift in the attitude of the Federal Government toward its responsibility for our poor and vulnerable citizens. This change in attitude has resulted in legislative action which has cut billions of dollars from Federal programs for children, the elderly, and the poor. Despite these cuts, Federal budget deficits grew to over $200 billion in 1986, due in large part to excessive military spending and revenue decreases. In 1985, the Urban Institute, one of the Nation's most respected think tanks, undertook a study to determine whether the truly needy have been protected from budget cuts, and this was their conclusion: "The promise of Federal protection for the truly needy and maintenance of a Federal effort on their behalf has not been met with respect to the low income elderly." That's desperately true, unfortunately.

It is these vulnerable elderly citizens who have suffered the most from Federal budget cuts. The President's fiscal year 1988 budget proposal, once again, would cut deeply into domestic programs by allowing military spending to grow excessively. It claims to reach the $108 billion Gramm-Rudman-Hollings deficit target by using unrealistic economic assumptions and relying upon many "one time only" loan and asset sales.

According to the Congressional Budget Office, the 1988 deficit under the President's budget actually would be $134 billion. As in the past, programs for the elderly have been singled out for some of the deepest cuts, particularly in the areas of health care and housing. The impact on programs for the elderly is as follows:

According to the CBO's budget analysis, Medicare would be trimmed $5.1 billion in 1988, and $52.7 billion over 5 years. The important fact is that nearly one-third of the total cuts would result from increased beneficiary costs. For example, the Part B premium for new Medicare beneficiaries would increase by more than one-third from 25 percent of program cost to 35 percent. Premiums paid by third parties, such as State Medicaid programs, would increase to 50 percent. Initial Medicare eligibility would be delayed for 1 month, saving $1.2 billion in 5 years, and what a melancholy farce that is. Somebody becomes eligible, let's say, on the first or second of the month, they lose the entire month's benefits and they must wait until the next month. And with the poor, this becomes almost sheer tragedy.

Forgive me. I'm digressing a minute, but I've almost come to the conclusion that the genes of this Administration have made it impervious to compassion. And if they want an instant case, that little month indicates that what I've said is not overstated.

The Part B deductible, now $75 a year, would automatically increase each year, tied to the rate of the Medicare Economic Index. This would save $400 million over 5 years, adding to the out-of-pocket costs for the approximately 70 percent of beneficiaries who meet the deductible each year. Recent Medicare expansions covering optometrists, occupational therapy, physician assistants and kidney dialysis would be repealed for a savings of $400 million. And what's to become of the poor who are afflicted by these health hazards is more than I could even imagine in my wildest conceptions.

Medicaid—the Administration would permanently cap Medicaid growth beginning with a $1 billion cut in 1988. Federal matching rates to the States would also be reduced for a total 5-year cut of $21.6 billion. These cuts would severely curtail States' abilities to provide health care to the poor. It should be noted that Medicaid is the only source of Federal aid for long-term nursing home care for the elderly and is available only to the poor.

Housing—virtually all new housing construction would be eliminated, including Section 202 housing for the elderly and the handicapped. The extent of Federal commitment to housing would be an expanded voucher program requiring the elderly, handicapped, and the poor to find their own housing in the private market. And a severe shortage of low-cost housing makes a voucher program unrealistic. Furthermore, vouchers result in savings because they are short-term commitments, 5 years as opposed to more traditional 15- to 20-year contracts.

Low income housing in rural areas would also depend primarily on vouchers. The Congregate Housing Service Program which helps prevent institutionalization by providing meals and services to the frail elderly in Section 202 and public housing facilities, would be terminated. Presumably, many of these beneficiaries would need to turn to Medicaid for nursing home care as a result. Now, Social Security—some of these issues have been mentioned, and I admired the comments of the Chair in regard to some of these observations that I'm about to make, too.

The Administration does not propose benefit cuts in Social Security, but they would cut its administrative funds despite a growing number of beneficiaries. These cuts would result in staff reductions of 2,454 in 1988 and by nearly 12,000 over 5 years.

The Low Income Home Energy Assistance Program would be reduced by one-third, and the Weatherization Program would be terminated. I could make a bitter speech about weatherization but I won't because you've been so damned patient that I mustn't tax your patience further.

The research conducted under the Older Americans Act would be cut in half.

It is clear to us that this budget proposal would be soundly rejected by Congress, and should be soundly rejected by Congress. I suppose I shouldn't say "would," but I believe it would be, will be.

NCSC believes it is possible to develop a budget which is both fair and responsible. The President's budget is neither. It would once again place the burden on the most vulnerable while allowing continued growth in defense, and it would reduce the deficit by using inaccurate economic assumptions and unwise one-time savings.

NCSC urges the Congress to restrain military growth and raise revenues responsibly, and spend the necessary funds for program improvements which are desperately needed. Specifically, we would like to draw attention to several improvements in the area of long-term care which are urgently needed.

When a chronic illness strikes, most older Americans find that the long-term services that they need are not covered by Medicare or other public programs or private insurance. As a consequence, many elderly persons and their families pay the full cost of the care out-of-pocket. The cost of long-term care has become the single greatest threat to the financial security of older Americans. Even with today's budget framework, we feel that concrete, important steps can be taken to improve the long-term care system in this country.

Due to time constraints, I will mention four areas which need attention.

One, a spouse should not be forced into poverty solely to enable the other spouse to receive needed nursing home care, which is the bitter fact now.

Two, the personal needs allowance of Medicaid's nursing home residents must be raised from the pitiful level of $25 a month. As you know, this is supposed to buy all of the things they need, whether they smoke or don't smoke, whether they take a beer or don't take a beer, or whether they want a Coca-Cola or a bar of chocolate or shaving cream or a toothbrush. We say $25 is not enough. I'd hate to have to survive on $25 under these circumstances.

Three, Medicare's definition of "intermittent care" must not be interpreted so narrowly as to restrict most care, which is the current practice.

Four, funding for the Older Americans Act has not kept pace with the growing need of an aging population, in particular the more costly needs of the frail elderly.

There, Mr. Chairman. I've taken a lot of your time, but at least I got it off of my chest. I'm putting it on yours.

[The prepared statement of Mr. Clayman follows:]

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The Proposal Fiscal Year 1988 Budget:
What It Means For Older Americans

Testimony Presented Before the
Senate Special Committee on Aging

by

Jacob Clayman, President
National Council of Senior Citizens
Washington, D.C.

March 13, 1987

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island **Second Vice President**, George J. Kourpias, Washington, DC
Third Vice President, Dorothy Walker, Detroit, Michigan **Fourth Vice President**, Everett W. Lehmann, Washington, DC
Secretary-Treasurer, Jack Turner, Detroit, Michigan **General Counsel**, Robert J. Mozer, New York

My name is Jacob Clayman. I am President of the National Council of Senior Citizens, which represents 4.5 million members in affiliated clubs throughout the country.

The National Council of Senior Citizens (NCSC) welcomes this opportunity to address the impact of the President's proposed budget on our nation's elderly. In doing so, it is important to view this budget in the historical context of recent budget actions.

Background: Historical Perspective on the Budget

Over the past six years, our nation has witnessed a fundamental shift in the attitude of the Federal government toward its responsibility for our poor and vulnerable citizens. This change in attitude has resulted in legislative actions which have cut billions of dollars from Federal programs for children, the elderly and the poor.

Despite these cuts, Federal budget deficits grew to over $200 billion in 1986 due, in large part, to bloated military spending and revenue decreases. While military spending was $136 billion in 1980, our government will spend over $300 billion for the military in 1987. Tax law changes since 1981 resulted in Federal revenue losses amounting to $446 billion.

Shortly after assuming the office of the President, Ronald Reagan addressed a Joint Session of Congress with the following pledge:

> "Those who through no fault of their own must depend on the rest of us, the poverty stricken, the disabled, the elderly, all those with true need, can rest assured that the social safety net of programs they depend on are exempt from any cuts."
>
> February 18, 1981

An examination of Federal programs serving the elderly, especially those "safety net" programs which serve the poor, reveals that this pledge has been violated. Without a doubt, senior citizens are significantly worse off now than when President Reagan took office, especially those who are poor and most dependent upon government services.

During each of the past five years, cuts have been enacted in the very safety net programs the President promised to protect. Those cuts were proposed in the President's budgets and enacted by the Congress.

As the safety net wore thinner, the President and many members of Congress continued to ignore the hardships that budget cuts were imposing on our nation's elderly and poor. Despite strong evidence to the contrary, the Administration has continued to insist that the "safety net" remains intact. The discrepancy between some of the President's statements and the real hardships faced by persons cut from services is astonishing.

According to the Congressional Budget Office[1], legislative actions taken between January 1981 and July 1983, resulted in the following Federal budget cuts (in billions of dollars) for fiscal years 1982 - 1985:

Social Security	- $24.1
Food Stamps	- $7.0
Housing Assistance	- $1.8
Low-Income Energy Assistance	- $0.7
Medicare	- $13.2
Medicaid	- $3.9
Community Services Block Grant	- $1.0
Social Services Block Grant	- $2.9

All these programs do not serve only the elderly or only the poor, and all the budget reductions were not direct cuts in benefits. But the cumulative impact of these changes has been seriously eroded Federal support for vital human service programs.

In 1985, the Urban Institute, one of the nation's most respected think-tanks, undertook a study to determine whether, in fact, the "truly needy" had been protected from budget cuts.[2] Their conclusion: "...the promise of federal protection for the truly needy and maintenance of federal effort on their behalf has not been met with respect to the low-income elderly."

The authors went on to state that, "changes in the major federal programs of Medicare, Medicaid, food stamps, housing, and transportation assistance have affected the low-income elderly in negative ways." According to the report, "the poor elderly often face impossible choices among food, shelter, utilities, and health care."

In addition to budget cuts enacted by Congress through the regular legislative process, the Gramm-Rudman-Hollings deficit reduction scheme heaped additional burdens on already-strained programs. While many programs for the poor were exempt from cuts, others such as the Older Americans Act programs and Low-Income Energy Assistance took a 4.3 percent cut in FY 1986, as a result of the Gramm-Rudman-Hollings budget sequestration.

What Comprises the "Safety Net" for the Elderly

Older persons depend more heavily on Federal assistance than any other age group. Social Security comprises the single largest source of income for the elderly and is received by over 90 percent of older Americans. Medicare, also, is received by nearly all older persons but does not cover many essential services such as prescription drugs, eyeglasses or hearing aids.

Medicare recipients must pay deductibles and co-payments for services and these out-of-pocket costs have escalated rapidly in recent years. For example, the Part A hospital deductible paid out of pocket by Medicare beneficiaries has risen from $204 in 1981 to $520 in 1987. Daily co-payments (after 20 days) for care in a skilled nursing facility have risen from $22.50 in 1981 to $65 in 1987.

A cost-saving measure was enacted in Medicare, beginning in 1984, based on a fixed-price system for particular conditions and referred to as Diagnosis Related Groups or DRGs. The DRG system has resulted in shorter average hospital stays for Medicare patients. However, many such patients are being discharged from hospitals in greater need of supportive services and nursing care--services which are not always readily available or covered by Medicare.

Ironically, the DRG system has also contributed to the rapid escalation in the cost of the Part A deductible. This deductible is based on the average cost of the first day in the hospital. Shorter hospital stays under DRGs have resulted in higher first-day costs, hence a more rapid increase for beneficiaries in the cost of their deductible.

Another increase for beneficiaries has been in the cost of the Medicare Part B insurance premium. Increases in this fee were formerly limited to the same percentage as the Social Security cost-of-living adjustment. They now equal 25 percent of total program costs. Appendix A illustrates the impact on beneficiaries of this change.

Low-income elderly persons may receive medical assistance through Medicaid, which is the major Federal-State program that finances health care for the poor. Medicaid is also the major source of public financing for long-term care, most notably, nursing home care. But while 3.2 million elderly persons receive Medicaid benefits, they reach only one-third of the non-institutionalized elderly poor.

The Medicaid program lost $1 billion a year in Federal matching funds between fiscal years 1982-1984 due to budget cuts. As a result, most states have had to restrict eligibility criteria and limit services provided.

Many elderly persons do not need to be institutionalized, yet they need help with tasks of daily living to remain independent. The Federal government provides funds to states through the Older Americans Act and the Social Services Block Grant (Title XX) to fund many of these needed services such as: senior meals programs, transportation and homemaker assistance. But these funds are limited and most programs must maintain waiting lists.

Supportive services such as these are essential to prevent premature institutionalization as an older person becomes more frail. Premature institutionalization is not cost-effective. It is also demeaning to the dignity of the older person who may need just a moderate degree of assistance in order to remain independent. But without regard for the long-term impact, funding for these programs has been cut.

New Federal spending on housing production and assistance has been cut by two-thirds since 1981. Although a study by the University of Michigan found a need for construction of 275,000 elderly housing units per year, new construction in the major Federal elderly housing programs has been cut from an average of 84,000 units a year in 1980-82 to less than 12,000 units in 1985. The average time on a waiting list for elderly housing is three to five years and only one in seven of the elderly poor receive any Federal housing assistance.

Other problems faced by the elderly stem from inadequate funding of programs for the poor. The major Federal income support program for the aged, blind and disabled poor is Supplemental Security Income (SSI), but its benefits amount to just 75 percent of the poverty line for an aged individual--a mere $340 a month. Benefits for a couple come to just $510 a month--about 90 percent of the poverty line.

The SSI program is designed to allow states to supplement the Federal benefit and, while many states provide some supplementation, almost none bring benefits above the poverty line. Also, many state supplements have not been adjusted, over time, for inflation. In addition, only about one-third of the elderly poor receive SSI, usually due to lack of information about the program.

Other programs for the poor fail to address adequately the needs of the elderly. Food stamp benefits usually amount to less than $45 a month and only about one-third of the elderly poor participate in the program, again, usually for lack of information. The Low-Income Home Energy Assistance Program (LIHEAP), which helps pay heating and cooling bills of poor households, receives only enough funding to serve about one-third of those eligible.

It is clear that the "social safety net" for the elderly is not a secure one. Yet, some have questioned how necessary a safety net is for the elderly. Certain media reports imply that there is no problem of poverty among the elderly, that older persons are uniformly affluent.

This is simply untrue. According to 1985 Census data, the median annual income for men 65 and older is just $10,900 and for women, a mere $6,313.3/ These numbers are lower than for any other adult age group. The 1985 poverty threshold for an elderly individual was $5,156, for an aged couple $6,503. Clearly, many of the elderly who escape poverty do so by just a small margin.

In 1985, 12.6 percent of the elderly were poor and almost 21 percent fell below just 125 percent of poverty. There are great disparities among poverty rates by race and gender. Not only is an elderly Black woman five times more likely to be poor than a White male, but persons who live alone and the very old (persons 85 and over) are twice as likely to be poor as those who live with others or the younger old.

The following chart, drawn from 1985 Census data, reveals the disparities in poverty rates among the aged:

1985 Poverty Rates

	Total	White	Black	Hispanic
Men 65+	8.5	6.9	26.6	19.1
Women 65+	15.6	13.8	34.8	27.4
Total	12.6	11.0	31.5	23.9
Persons 65+ Below 125% of Poverty	20.9	18.8	44.9	34.8

It is these most vulnerable elderly citizens who have suffered the most from Federal budget cuts. In addition, not only is the U.S. elderly population increasing rapidly, but the most vulnerable segments are growing more quickly than are the aged overall.

The contention that Federal budget cuts could be replaced at the local level has not occurred. The Urban Institute Study found that the combination of block grants and Federal budget cuts resulted in, "poorer services to fewer people and made the availability of those services contingent on the values and priorities of a jurisdiction."

A study of the funding sources for Older Americans Act programs conducted by the National Data Base on Aging found, "...no evidence... which would suggest that state and local governments or the private sector have the capacity or the commitment to replace lost Federal funds or to add to the resources available to meet the needs of an expanded elderly population."[4]

The President's Proposed Budget for Fiscal Year 1988 and the Elderly

The President's FY 1988 budget proposal, once again, would cut deeply into domestic programs while allowing military spending to grow excessively. It claims to reach the $108 billion Gramm-Rudman-Hollings deficit target by using unrealistic economic assumptions and relying on many one-time-only loan and asset sales.

According to the Congressional Budget Office (CBO), the FY 1988 deficit under the President's budget actually would be $134 billion.[5] Relatively small differences in economic assumptions result in substantially larger deficit estimates by CBO.

In order to increase real defense appropriations by three percent in 1988 and reduce the deficit, the Administration would cut nondefense spending and increase revenues by $44 billion in 1988. But, many of these transactions are loan and asset sales which would reduce outlays in 1988 at the cost of increased spending later on, according to CBO.

As in the past, programs for the elderly have been singled out for some of the deepest cuts, particularly in the areas of health care and housing. The impact on programs for the elderly is as follows:

Medicare

According to CBO's budget analysis, Medicare would be trimmed $5.1 billion in FY '88 and $52.7 billion over five years. Nearly one-third of the total cuts would result from increased beneficiary costs. For example:

- The Part B premium for new Medicare beneficiaries would increase by more than one-third--from 25 percent of program costs to 35 percent. Premiums paid by third parties, such as state Medicaid programs, would increase to 50 percent.

The following chart indicates the impact this proposal would have on monthly premiums.

Estimated Monthly Premiums
(By fiscal year, outlays in dollars)

	1988	1989	1990	1991	1992
CBO Baseline	22.00	22.90	23.90	24.90	26.00
President's Budget as Estimated by CBO					
Current enrollees	21.70	24.00	26.50	29.30	32.30
New enrollees	30.30	33.50	37.10	41.00	45.20
Third-party payers	43.30	47.90	53.00	58.60	64.50

The increased rates for third-party payors would result in higher Medicaid costs--about $600 million in '88--since Medicaid pays these premiums for low-income elderly in some states. States would not, however, receive additional Medicaid funds to absorb these higher costs. Instead, Medicaid funds to states would be substantially reduced.

- Initial Medicare eligibility would be delayed for one month, saving $1.2 billion in five years.

- The Part B deductible, now $75 per year, would automatically increase each year tied to the rate of the Medicare Economic Index. This would save $400 million over five years, adding to the out-of-pocket costs for the approximately 70 percent of beneficiaries who meet the deductible each year.

- Recent Medicare expansions covering optometrists, occupational therapy, physician assistants and kidney dialysis would be repealed for a saving of $400 million.

Most of the remaining Medicare proposals would affect payments to hospitals and doctors, many of which are warranted, and by requiring that all state and local employees be covered by Medicare. Several provider reforms, however, would cause serious problems.

First, the Administration intends to pay its bills more slowly by increasing the number of days bills remain with the Medicare contractors responsible for processing claims. The Omnibus Budget

Reconciliation Act of 1986 (OBRA-86) established maximum time periods in which most claims must be paid. The Administration plans to slow down payments so that the legislative limits become a minimum as well as a maximum.

Second, the President proposes that certain hospitals which serve a disproportionate share of low-income patients would no longer receive reimbursement on a Periodic-Interim-Payment (PIP) basis. Instead, they would be paid as their bills were submitted and processed, thus slowing down their reimbursement by several weeks.

These proposals would simply shift $2 billion in outlays from 1988 to 1989 while creating financial hardships for some small providers and hospitals which serve the poor. In some cases, Medicare beneficiaries have been harassed by collection agencies when Medicare has delayed payment of their claims.

Medicaid

The Administration would permanently cap Medicaid growth, beginning with a $1 billion cut in '88. Federal matching rates to states would also be reduced for a total five-year cut of $21.6 billion. These cuts would severely curtail states' ability to provide health care to the poor. It should be noted that Medicaid is the only source of Federal aid for long-term nursing home care for the elderly and is available only to the poor.

Housing

Virtually all new housing construction would be eliminated, including Section 202 housing for the elderly and handicapped. The extent of Federal commitment to housing would be an expanded voucher program requiring the elderly, handicapped and poor to find their own housing in the private market. A severe shortage of low-cost housing makes a voucher program unrealistic. Furthermore, vouchers result in savings because they are shorter-term commitments--five years as opposed to more traditional 15-20 year contracts.

Low-income housing assistance in rural areas would also depend primarily upon vouchers.

The Congregate Housing Services Program (CHSP) which helps prevent institutionalization by providing meals and services to the frail elderly in Section 202 and public housing facilities would be terminated. Presumably, many of these beneficiaries would need to turn to Medicaid for nursing home aid as a result.

Social Security

The Administration does not propose benefit cuts in Social Security, but would cut its administrative funds, despite a growing number of beneficiaries. These cuts would result in staff reductions of 2,454 in 1988 and by nearly 12,000 over five years.

Low-Income Home Energy Assistance Program and Weatherization

Low-income energy assistance programs which serve large numbers of poor elderly households are slated for deep reductions. Not only would the weatherization program be eliminated in 1988, but $112 million would be rescinded in 1987. The weatherization program helps poor families make their homes more energy-efficient, thereby reducing future energy costs.

Funding for LIHEAP, which helps pay heating and cooling bills for the poor and helps prevent utility cutoffs, would be cut by more than one-third, from $1.8 billion to $1.2 billion in FY '88. The '87 level had already been cut from the FY '86 level of $2 billion, although only about one-third of eligible households receive aid.

The rationale for this cut is that states have received settlements from oil overcharge cases that can be used for this program. But, there is no requirement that funds be spent on LIHEAP and, in fact, it appears that only a small proportion of oil overcharge funds are being spent on LIHEAP.

The Administration would also attempt to cut Food Stamp benefits for LIHEAP recipients, despite Congressional prohibitions on such restrictions.

- COMMUNITY SERVICES BLOCK GRANT (CSBG)

CSBG is scheduled for "phase out" and would suffer a $58 million cut in FY '88 to $310 million, with complete elimination in four years. This program funds services for the poor, such as food and fuel assistance.

- LEGAL SERVICES CORPORATION

The legal services corporation, which provides free legal assistance to low-income persons, many of them elderly, would be terminated. FY '87 funding is $305.5 million.

- AGING RESEARCH

Included in the Older Americans Act, this program would be cut by 50 percent, or $12.5 million. Other Older Americans Act funding for meals, services and employment would be consolidated with 26 programs into a "generic appropriation" with a 23 percent cut by 1992.

It is clear to us that this budget proposal should be soundly rejected by the Congress. NCSC believes it is possible to develop a budget which is both fair and responsible. The President's budget is neither. It would once again place the burden on the most vulnerable while allowing continued growth in defense and it would reduce the deficit by using inaccurate economic assumptions and unwise one-time savings.

NCSC urges the Congress to restrain military growth, raise revenues responsibly and spend the necessary funds for program improvements which are desperately needed. Specifically, we would like to draw attention to several improvements in the area of long-term care which are urgently needed.

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private Medigap insurance. As a consequence, many elderly persons and their families pay the full cost of their care out-of-pocket. The cost of long-term care has become the single greatest threat to the financial security of older Americans.

Even with today's budget framework we feel that concrete, important steps can be taken to improve the long-term care system in this country.

First, nearly 800,000 Medicaid nursing home residents depend on their "Personal Needs Allowance" each month--only $25.00 a month, or 82 cents a day--to cover a wide range of living expenses not paid for by Medicaid.

The PNA is used to purchase basic supplies like toothpaste and shampoo, eyeglasses, clothing, laundry, newspapers and phone calls. In 15 states, more than half of the $25 must be spent on laundry alone. In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by state Medicaid programs. Although the Personal Needs Allowance is not intended to cover medical items, these residents may have to save their PNAs over many months to pay for these costs, preventing them from tending to personal needs. In addition, if a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay the bed reservation fee is likely to lose his place in the facility, 40 percent of state Medicaid plans provide no coverage for bed reservations.

The $25 PNA has not been increased--even to adjust for inflation--since Congress first authorized payment in 1972. As a result, the PNA is worth less than $10 today. This means that all recipients of Social Security or SSI benefits have received COLAs to their benefits since 1974, except the frailest and most vulnerable--Medicaid nursing home residents.

The National Council of Senior Citizens advocates that Congress increase the PNA by $10 per month, plus a COLA, in order to restore just some of the purchasing power that nursing home residents have lost over the years.

The second step we must take this year is to ensure that one spouse is not forced into poverty solely to enable the other spouse to receive needed nursing home care.

In most states, older persons are eligible for Medicaid only if they meet the income standard of the Supplemental Security Income (SSI) Program which is below the Federal poverty threshold. Some states use even moe restrictive eligibility criteria.

At an average annual cost of $22,000, the expense of nursing home care quickly exhausts the resources of most persons. Only then does Medicaid assistance become available.

When an institutionalized person with a living spouse becomes Medicaid eligible, the law assumes that all marital income is available to cover the cost of nursing home care. After one month, the spouse at home, often the wife, may retain her own income and resources, if she has any left. Unfortunately, the wife is often dependent upon a portion of her husband's income, in which case Medicaid provides for a "spousal maintenance allowance." Federal law puts a ceiling on this allowance comparable to the SSI income standard or the state's "medically needy" standard. This usually results in about $350 to $400 a month being allocated to the spouse at home and, in some cases, the allowance is even less.

NCSC, as a part of a coalition of senior advocacy groups concerned with this issue, urges Congress to solve these problems and the terrible choices they force seniors to make as follows: First, end deeming of resources and income when one spouse is admitted to an institution; second, set a uniform Federal minimum spousal maintenance allowance equal to 150 percent of the Federal poverty line for couples, plus an adjustment for shelter costs and marital income; and, third, exclude liquid assets owned by the institutionalized spouse or by both spouses jointly up to $12,000 in fair-market value for purposes of determining Medicaid eligibility.

A third major problem in long-term care that the Congress needs to address this year is the unlawful and miserly limits that the Health Care Financing Administration (HCFA) has placed on the Medicare home health benefit. Four requirements must be met in order for Medicare beneficiaries to be eligible for Medicare home health benefits. One of the requirements is that the patient must require intermittent or part-time care. That is, if the patient needs full-time home health care, he or she is not eligible for the benefit. Since 1981, HCFA has used its own interpretation of the intermittent requirement to inappropriately restrict use of the Medicare home health benefit.

This problem has manifested itself in many ways. In 1980, Congress removed the limit on the number of visits allowed under the Medicare home health benefit. This action represented a major statement by the Congress that it was fully in favor of providing home health care to those in need and that it supported use of home care services as a substitute for costly institutional care. In 1981, however, HCFA issued instructions that had the effect of limiting the length of the home health benefit to no more than two or three weeks of part-time home health care. HCFA has also interpreted part-time to mean that even visits of only one or two hours each day constitute full-time care. As a result, many beneficiaries who need home health care beyond the two or three week "limit" are denied Medicare coverage.

These definitional squabbles might be no more than a thorn in the side of many seniors seeking the care they need if the problem hadn't been greatly exacerbated by implementation of the Medicare prospective payment system. When Congress, in 1983, moved to require the PPS system for Medicare hospital services, it did so with the deliberate reasoning that PPS would encourage greater use of less costly, more appropriate care in post-hospital settings--specifically at home and in skilled nursing facilities. And the health care system has responded exactly as Congress had intended and in accordance with the financial incentives put in place under PPS. Since 1983, hospital discharges to home health care are up 37 percent, senior citizens are leaving hospitals sooner and in greater need of care than ever before, and the provider community has responded to these needs by attempting to provide care and higher levels of care to more individuals at home.

This natural, correct, intended result of Congress' 1983 actions has not met with HCFA's approval, however. By all indications, it would appear that HCFA is trying to restrict use of the home health benefit to pre-1983 levels, even though the intent of Congress was to deliberately encourage greater use of this type of care. And creative use of the intermittent definition seems to be one of the most effective tools HFCA has in achieving this goal.

As a result of their creative energies, home health services are less available at a time when they are more needed than ever before, and Medicare patients are being forced to go without care they need, or pay out of their own pockets for care that they are entitled to under the law.

We believe that Congress should reassert its authority and its original intent that the home health benefit under Medicare should be available to senior citizens and that it should be used to provide needed transition care by explicitly stating in statutory language that the Medicare home health benefit should be available on a part-time basis to seniors in need of this care for up to 60 days, thereafter as certified by a physician that the care is still medically reasonable and necessary and that all other home health requirements are met.

Finally, NCSC believes that more funding is needed for the Older Americans Act programs which are being reauthorized this year.

First, more persons are living to be 85 years and older and tend to be more frail and impoverished than their younger counterparts. Whereas 9.4 percent of the elderly were at least 85 in 1985, by 2010, this proportion is projected to be nearly 17 percent--an increase of almost four million individuals. In-home and community-based long-term care services can help such persons remain independent, thus preventing costly and unnecessary institutionalization. Another increasing group of persons in dire need of such services are those released "quicker and sicker" from hospitals as a result of the DRG system. Additional resources provided now will be cost-effective in the long run by maximizing the independence of the frail elderly.

Second, the OAA directs that service priority be given to poor and minority elderly, but additional funds are not provided to those states with large concentrations of poor elderly. NCSC advocates a revised formula for distributing any increase in funding to more effectively target areas of greatest need. According to the Administration on Aging, there has been a substantial drop in low-income participation in meals and services provided under Title III of the Act. Additional funds, more effectively targeted, could help reverse this trend. Appendix B contains figures on this trend.

Third, increasing numbers of senior citizens want and need to re-enter the labor force or remain employed on either a full- or part-time basis. Ignoring the employment needs of older workers has costly consequences, such as increased demand for Supplemental Security Income, Unemployment Compensation and a variety of other public assistance programs. The Senior Community Service Employment Program, Title V of the OAA, provides part-time employment for low-income persons age 55 and over in public service jobs. Although Title V has enjoyed bi-partisan Congressional support, it currently serves only about one percent of all eligible older workers nationwide (approximately 64,000). Moreover, while all other titles of the OAA received increased appropriations in FY 1987, Title V funding has remained frozen at $326 million--without even an increase for inflation--since 1985.

An increase of $100 million, over inflation, with a 70/30 split for Title III/Title V, would make important progress in improving essential programs for poor and frail seniors.

These steps would begin to address some of the needs of the elderly. NCSC thanks the Special Committee on Aging for holding this important hearing.

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APPENDIX A

MEDICARE PART B SUPPLEMENTARY MEDICAL INSURANCE PREMIUM RATES

TIME PERIOD	MONTHLY PREMIUM	PERCENTAGE INCREASE FROM PREVIOUS YEAR
July 1, 1975 through June 30, 1976	$6.70	0
July 1, 1976 through June 30, 1977	$7.20	7.5%
July 1, 1977 through June 30, 1978	$7.70	6.9%
July 1, 1978 through June 30, 1979	$8.20	6.5%
July 1, 1979 through June 30, 1980	$8.70	6.0%
July 1, 1980 through June 30, 1981	$9.60	10.3%
July 1, 1981 through June 30, 1982	$11.00	14.6%
July 1, 1982 through Dec. 31, 1983*	$12.20	11.0%
Jan. 1, 1984 through Dec. 31, 1984	$14.60	19.7%
Jan. 1, 1985 through Dec. 31, 1985	$15.50	6.2%
Jan. 1, 1986 through Dec. 31, 1986	$15.50	0
Jan. 1, 1987 through Dec. 31, 1987	$17.90	15.5%

*Schedule of Premium rate increase and Social Security COLA was changed to calendar year basis.

APPENDIX B

Targeting of Older Americans Act Services

CONGREGATE MEALS

	1981	1982	1983	1984	1985
Total # of Meals	143 m	140 m	145 m	147 m	150 m
Total # of Persons	2.8 m	2.8 m	3.2 m	2.9 m	2.9 m
Greatest Social Need	1.3 m (46%)	1.4 m (50%)	1.5 m (49%)	1.6 m (54%)	1.6 m (54%)
Greatest Economic Need	1.7 m (60%)	1.7 m (61%)	1.8 m (56%)	1.6 m (56%)	1.6 m (53%)
Minority	535,000 (19%)	501,000 (18%)	591,000 (19%)	496,000 (17%)	475,000 (16%)

HOME-DELIVERED MEALS

	1981	1982	1983	1984	1985
Total # of Meals	45 m	51 m	58 m	67 m	75.5 m
Total # of Persons	568,000	517,000	611,000	611,000	693,000
Greatest Social Need	361,000 (64%)	370,000 (72%)	390,000 (64%)	431,000 (71%)	483,000 (69%)
Greatest Economic Need	372,000 (66%)	349,000 (67%)	370,000 (61%)	388,000 (63%)	447,000 (64%)
Minority	109,000 (19%)	103,000 (20%)	115,000 (19%)	114,000 (19%)	120,000 (17%)

SUPPORTIVE SERVICES

	1981	1982	1983	1984	1985
Total # of Persons	8.9 m	9.1 m	9.2 m	9.1 m	9.3 m
Greatest Social Need	3.7 m (42%)	4.1 m (44%)	4.3 m (47%)	4.5 m (49%)	4.4 m (47%)
Greatest Economic Need	4.5 m (51%)	4.7 m (52%)	4.7 m (51%)	4.3 m (47%)	4.0 m (43%)
Minority	1.6 m (18%)	1.7 m (18%)	1.6 m (18%)	1.6 m (18%)	1.5 m (16%)

m = million

Source: Administration on Aging, Summary of Program Performance

The CHAIRMAN. Well, Jake and Mr. Lehrmann, I think it's good testimony. I hope that this hearing record is read by committee members and other Americans so they can contemplate some of the truth about older Americans.

I have no argument with anybody who wants to submit facts, as has been done earlier here today by some of those trying to point out that the Administration's proposals in the budget weren't as bad as might seem, because there are factual data that can point out that there's more money spent than there was 15 or 25 years ago. In fact, we looked at a budget chart that one of the Senators had prepared to make that case.

But that's misleading, and that's not what we're talking about. We're talking about the real world, the real situation as it exists today, and no span of figures will get by these facts, at least as found by the Villers Foundation, and I think they are accurate facts, that the elderly have the second highest poverty rate among age groups. The second highest poverty rate. And what's the other age group that is higher that the elderly? Children.

There has been a different poverty standard used by the Census Bureau for those who are 65 or older than is used for those under 65, and that's a little-known fact. It is contemplated by the Census Bureau that you can be desperate more easily when you get to be over 65 than you were before 65. I have a hard time following that logic, but the standard is different after you're 65 than it is before.

And so when they say that there are 3.5 million Americans age 65 or over who were in poverty in 1985, that means that there are more than that if you use the same standards before you turned that 1 day to make you 65.

If the same standard were applied to the elderly as the standard used for those under 65, the elderly poor—those in poverty—would increase to as high as 4.2 million, increasing the poverty rate for the elderly from 12.5 percent to slightly over 15 percent.

And then if we want to get into minorities, of course, we find it even worse. Over 31 percent of older blacks are poor compared to 11 percent of those of us who are white.

But the most cruel thing of all, I think, is that elderly women account for over 72 percent of the elderly poor.

Additionally, Villers found that there are huge numbers of older Americans who hover near poverty or are economically vulnerable, and approximately 8 million elderly are in this category. This is 11.5 million elderly Americans, or 42 percent of the total age population, the elderly population, that are poor or economically vulnerable.

You know, that's a little different than just looking at the broad brush strokes of how much money is spent. We're not keeping up.

Improving health care, for example, is a good example of this. Quality health care—for all Americans—is basic and fundamental to us as a people. We are determined to improve our medical care and hospital care and drug care. We grew up that way, and we're not going to change. And we continually press forward in those fields. I would hate to think that we're setting the stage to start a retrogression in health care for when I get there. It's that simple. Part of my interest is selfish; I admit that. It's very much tied to me. I don't want that, and I don't think any Americans do.

I think that we'll knock down the President's budget and get a decent budget, but I've got a few questions I'd like to ask you while I've got you here because I think your counsel and knowledge is very helpful to the committee.

Mr. Lehrmann, Jake indicated that he felt that the defense spending in the President's budget was too high compared to what it was for the elderly. Now, we know that we're going to have to make some budget cuts. If we do the right thing for the elderly we've got to make some cuts somewhere else, and I'm asking you, Mr. Lehrmann, what is your recommendation?

Mr. LEHRMANN. Sir, our recommendation in terms of trying to deal with this situation would be to do it in a balanced fashion. One of the things that we would suggest is that a balanced approach be taken to reduction in the military budget. We also would look to some increases in taxes, in revenue, in order to cover this; and if there are some other places to make savings, we certainly would not object to that. But our point is that it should not fall on the elderly and on human services but should be spread equitably across the population. That has to include, in our judgment, some increase in revenues as well.

The CHAIRMAN. Well, what would happen if we would have both an increase in Medicare Part B payments, and enacted the Bowen proposal for catastrophic coverage as it affects hospital costs for those on Medicare?

Mr. LEHRMANN. It would substantially increase the cost to the beneficiaries. This is a shift of cost to the beneficiaries. Obviously, we support catastrophic coverup. Dr. Bowen's plan does not go far enough, Senator, that's for sure, because we need to address the whole question of what are we going to do in terms of long-term care? That's the issue. We're concerned also with the whole question of spousal impoverishment as it now exists under Medicaid.

So those are the things that we're targeting on, and as far as we're concerned, that increase of cost—both in premium for the catastrophic and in the premium itself, if it's as it's proposed—would be something that certainly, for those that are in the lower income category, would be devastating.

The CHAIRMAN. Well, 97 percent of the people on Medicare have Part B. Would we risk losing part of those if we raised both Part B and the $4.92 or whatever it is that it would cost to finance the Bowen proposal?

Mr. LEHRMANN. I suppose that's always a risk, Senator, and we think there probably would be some dropoff in that participation. However, people have to make real decisions when they're in the lower income category. They have to decide between medical care, food, shelter, and clothing; and sometimes medical care falls off the end because it's something that they feel they can get along without for a while. The end result is more devastating than if they were able to take care of their needs immediately. Yes, there may be some concern that we would lose somebody if we take that approach.

The CHAIRMAN. Both of you, now, have spoken of the truly significant catastrophic protection that the elderly look for, that is, for long-term care whether it's at home or in a nursing home. And of course, I share your view on that; I think that's extremely important. When we get the opportunity to act on the Bowen proposal, we should go much farther than just covering the catastrophic hospital part and pick up the most significant catastrophic problem that faces the elderly—long-term care expenses.

Jake, we're going to have to finance that. If people say, well, we can't take it out of the Treasury—and, I'll tell you for my part, it's so high a priority I'd take it out of the Treasury unless somebody had a better idea. But I have to face the reality of votes, and when we get to that part—what can you suggest in terms of raising the revenue that would be necessary?

Mr. CLAYMAN. Well, I suspect that the first item would be raising the efficiency of the medical profession and their costs——

The CHAIRMAN. In other words, a reduction in their costs and the hospital's?

Mr. CLAYMAN. As well as the hospital's. You know, we imposed that program that has made it apparently more profitable for hospitals to send people home speedily, cut their costs, but it hasn't cut their profits. We heard that today; I heard it several times. I've read it over and over again. It's true.

The CHAIRMAN. I think their profits might be up.

Mr. CLAYMAN. Yes, 15 percent last year, profits, when they are complaining over and over and over again that they don't have the money to take care of things; and the very poor who can't afford to pay, they treat by the thousands and they lament the position they're in. Notwithstanding, they're making 15 percent profit, and that would be a beginning point.

Doctors charge too much. I've gone to the same doctor for 26 or 27 years, and he's a personal friend of mine by this time. But he charges too much. And I don't begrudge him having a decent living, but when you multiply this and impose this load on all kinds of people—not on me; I have kind of a middle income for myself and my wife, and I manage to get along, and I can pay his fee—but there are thousands and millions who can't.

And so first, it seems to me that we ought to be fair but firm with the medical profession, with the hospitals, with the drug companies and all the rest. That would be a sizeable, sizeable—I can't give you a figure because I really don't know that figure, but I guess it would stagger your imagination and my imagination if we knew what it was.

And it conceivably may be that when we come to the point that we really will take care of long-term illnesses, really take care, then maybe there ought to be for some categories some additional compensation paid—stipends paid—by people like myself and others like me, although I don't mean to tread on a system such as some would like, namely, a complete system of means testing. There's something almost indecent in some areas about this. It—well, I won't go into that further. But if I were to make my "Carthage Must Be Destroyed" speech, and it isn't relevant at this moment in this hearing, I'd make as impassioned a statement for a national health program that serves everybody, like the British, like the Canadians—particularly the Canadians—everybody. And we're almost the only Nation among the industrial nations that doesn't do that, but even considers it indecent—or even communistic, or socialistic, whichever term they think is the most despicable.

That's really in the long run, and you may be around in your time; you're still a youngster—in your time maybe it will come to pass. It isn't relevant here, but I just throw that in for the hell of it. [Laughter.]

Mr. **Lehrmann**. Mr. Chairman, I'd like to comment on one of Jake's points if I might, because it relates to our thinking as well. That has to do with trying to pay for the cost of long-term care by the elderly themselves. I frankly think that we have to look at this as an intergenerational problem that we all share in, and financing has to come from the broad population base.

If we start doing that, Mr. Chairman, then do we start saying that because older people don't use as big a portion of the educational dollar that we should stop paying our property taxes or not pay them on education? I think these are all intergenerational problems, and we should approach them on that basis.

Wasn't our Federal income tax program designed so that those who could afford to pay would pay more? And if we aren't applying it that way, our question would be, why don't we? And if we do, then some of that revenue could be designated to be applied toward long-term care. But we think that's a reasonable thing, rather than just shifting costs between older people and imposing something on us at that point.

The **Chairman**. There is another question, you know—in the Bowen proposal, it's $2,000 out-of-pocket before you get the balance of it paid, under his proposal. That's just for the acute catastrophic, and we all recognize that the much greater catastrophic situation we face is long-term health care.

What should the threshold be for that? Because that will make a great deal of difference on what the cost is.

Mr. **Clayman**. It should not be $2,000. I've been seeing it over and over again in print—and if you would ask me if I've done independent research on it, no—but over and over again I've seen in print that the percentage of people who spend that much is 3 percent. Three percent of the people who spend that much, the elderly people, would be affected, which means that a cohort—a relatively small group—would have the benefit of the program at all to begin with, because first you have to spend $2,000 a year, and not too many elderly spend that much. And particularly those who are poor, they have to die before—and maybe on their funeral they might spend a few thousand dollars, a couple thousand dollars or hundreds of dollars, but they never would be eligible because they would not comply with the determination that you have to spend at least $2,000 before you become eligible for assistance, as Mr. Bowen suggests.

Now, what should that figure be? Well, we've been saying, at least in our office—and I think we've said it before hearings—that if we're going to move in that direction, it should be down to $500.

The **Chairman**. To $500?

Mr. **Clayman**. To $500 so that at least it draws the circle broadly enough so that it makes a difference.

The **Chairman**. Mr. Lehrmann.

Mr. **Lehrmann**. Well, we've looked at it, and we're talking about covered services here, Senator. We looked at it for acute care and we thought $1,000 under Part B plus one Part A deductible was a fair approach if we were going to look at this issue.

The CHAIRMAN. Now, that would also cover long-term care?

Mr. LEHRMANN. Oh, you'd add that on a much broader proposal. I would expect that we'd have the same position, but that's another question that we haven't looked into.

The CHAIRMAN. Well, $1,000 under Part B, and $1,000 deductible on Part A?

Mr. LEHRMANN. It's $520 now, Senator.

The CHAIRMAN. On Part A?

Mr. LEHRMANN. Yes.

The CHAIRMAN. All right.

Now, I want to ask both of you about OHDS and that proposal for a generic appropriation that's in the President's budget. What is each of your reaction to that?

Mr. CLAYMAN. Instead of having Ms. Kassner whisper in my ear, I'm going to have her say it out loud.

The CHAIRMAN. Surely.

Ms. KASSNER. We have opposed a generic appropriation approach for OHDS. It is accompanied by a reduction in funds and would give, we believe, undue discretion to the department as to how the funds would be allocated among the programs.

Mr. LEHRMANN. We oppose that approach as well, Senator. I don't think we need to elaborate on that.

The CHAIRMAN. I think that's going to be about unanimous. I thought that the reasons that were stated about why it's in the budget that way were very weak.

But the point is, we're just learning about what can be done through these programs. We don't know everything yet. We found some good ways of improving the quality of life and the satisfaction of people in their older years and let them have a little fun and enjoyment, and I think we're just starting on that. I think these Older American Act programs are going to become a much broader attempt to enrich the lives of all of us.

So I would certainly want these programs to proceed, and sort out as we go along which need more money because they bring a lot more results. It's kind of seed money. I was talking at some length about what they're doing with these congregate meals. I know my experience with visiting senior citizen centers; that's a big deal. Everybody has fun, and it's a social occasion. That's what I'm talking about; how do we improve the opportunity to have more fun and enjoyment and interrelationships so that you're not so isolated? I think maybe the greatest fear of all—my fear, anyway—would be if I thought I had to be isolated. And I think that's a way of overcoming it for older Americans.

I want to thank both of you very much for your testimony and also for your leadership for older Americans. You are both outstanding, and I think all of us appreciate that.

Mr. LEHRMANN. Thank you very much, Senator, for inviting us. We appreciate speaking for older people, believe me.

The **Chairman**. Thank you.

The record will be held open for any additional statements that anybody would like to submit in written form. We'll keep it open for 10 days.

Committee adjourned.

[Whereupon, at 1:40 p.m., the committee was adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

PROPOSED FISCAL YEAR 1988 BUDGET

What It Means For Older Americans

ANALYSIS

U.S. SENATE SPECIAL COMMITTEE ON AGING

THE HONORABLE JOHN MELCHER, CHAIRMAN

March 13, 1987

FORWARD

This is a preliminary analysis of the Administration's proposed Fiscal Year 1988 budget and its impact on older Americans. It was prepared by the Majority staff of the U.S. Senate Special Committee on Aging. Figures used in this report are based predominantly on current budget projections by the Congressional Budget Office.

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Chapter 1 -- Health

MEDICARE

The Program

In response to concerns that too many older Americans could not afford -- and did not have access to -- essential medical care, the Medicare program was enacted in 1965. The program was designed to provide insurance protection against short-term (or acute) illness. The hospitalization component (Part A), which pays for inpatient hospital and hospice care, short-term stays in skilled nursing facilities, and a limited amount of home health services, is financed principally through a special hospitalization insurance payroll deduction included as part of the Social Security tax. The Supplemental Medical Insurance component (Part B), which pays for all other covered services, principally physician services, is financed through general revenues and premium payments from beneficiaries who elect to buy the coverage. 95 percent of Medicare beneficiaries choose to buy Part B coverage.

In 1988, an estimated 29 million elderly and 3 million disabled persons will be eligible for Medicare. Despite the important protection that Medicare provides, it covers less than half of all personal health care expenditures for the elderly. Fiscal Year 1987 Medicare outlays are estimated to be $71.6 billion. CBO estimates that $83.1 billion in outlays would be required to meet current law service levels for FY 1988.

Administration's Proposed Fiscal Year 1988 Budget

The President's FY 1988 budget request provides $73 billion in net outlays for the Medicare program. This is $10.1 billion, or 13 percent below the CBO current services estimate for FY 1988. He proposes a number of changes in Medicare that would reduce spending by $5.1 billion in FY 1988 and $52.7 billion over the 1988-1992 period. The additional $5 billion discrepancy is attributable to a number of factors including the differences in assumed annual growth in hospital services. While CBO's estimate assumes a continuation of recent growth trends, the Administration's estimate assumes that growth rates will decline from recent experience.

Beneficiary Impact:

For fiscal 1988, the President's request raises $900 million, and over $17 billion from fiscal 1988-1992, by increasing direct costs to beneficiaries. Key proposals include:

--Premiums.--Would increase Part B monthly premiums from 25 percent of program costs to 35 percent for new enrollees and to 50 percent for premiums paid by third parties, such as state Medicaid programs. This proposal would produce a savings of $700 million in FY 1988 outlays and is **the first time an Administration's budget proposal has distinguished between current and future enrollees.** CBO estimates that current Medicare enrollees would pay $21.70 per month, new enrollees would pay $30.30 per month (over 40 percent more than current beneficiaries), and third party payers would pay $43.30 per month (over 100 percent more than the current premium.

--Eligibility.--Would delay Medicare eligibility for one month. CBO estimates this proposal would produce a FY 88 outlay savings of $200 million. This proposal, the sixth year that the President has offered it, likely would create a gap in medical coverage for at least 10 percent of new enrolleess (200,000 people next year). There is no assurance that employers will continue to pay for another month's coverage.

--Deductibles.--Would increase the Part B $75 deductible each year by indexing it to the Medical Economic Index (MEI). This proposal would cut $400 million in outlays between FY 1988 and FY 1992 and would increase this deductible by $4 to $5 per year. Should the proposal be enacted, the deductible is estimated to reach $120 by 1992.

--Secondary Payer--Would extend Medicare secondary payer status for the working elderly and disabled who elect to take advantage of employer-provided health insurance from large (more than 100 employees) to medium-sized employers (more than 20 employees). This proposal would save $300 million over the five-year projection period.

--Vouchers.--Proposes to give Medicare beneficiaries the option of receiving a fixed sum or credit to purchase private health insurance in lieu of Medicare coverage. The budget impact of this proposal is unclear, but the national standards regarding covered benefits, quality safeguards, and appeal mechanisms may be compromised.

Provider Reimbursement:

The Administration also proposes to reduce expenditures by restraining Medicare reimbursement to health care providers by $2.1 billion in fiscal year 1988 and $31.7 billion over the next five years. Key proposals include:

--Part A Providers.--Would restrict the increase in prospective payments to hospitals. This proposal would save $500 million in FY 1988 outlays and $17.9 billion over the five-year projection period. It is unclear how this proposal would affect the provision of quality care.

--**Part B Providers.**--Proposes that radiologists, anesthesiologists, and pathologists (RAPs) be reimbursed through the prospective payment system for hospital services. This proposal would save an estimated $10 million in 1988 and $500 million over five years. In addition, the President proposes to repeal provisions of the Omnibus Budget Reconciliation Act of 1986 which extended Medicare coverage to services provided by physician assistants, occupational therapists and optometrists. Elimination of coverage for these professionals will save $400 million over five years, but also would reduce access to these important services. The Administration also proposes to pay new physicians at approximately 80 percent of the local prevailing charge. This proposal would save $700 million over five years.

--**Capital Costs.**--Would change payments to hospitals for capital costs from cost reimbursement to a prospective payment system. This proposal would be phased in and would be budget neutral until 1990. Savings from 1990 through 1992 are estimated at $2.1 billion.

--**Medical Education.**--Would lower reimbursement for direct payments (such as residents' and teachers' salaries, classroom expenses, and associated overhead) and indirect payments (for such costs as the greater number of tests prescribed by interns and residents). This proposal is estimated to save $1.2 billion in fiscal 1988, but would have an adverse effect on the poor elderly who obtain low-cost health care through these medical training programs.

Other Proposals:

The President's budget contains other proposals designed to reduce Medicare outlays including:

--**Delaying Outlays.**--Proposes to reduce Medicare outlays by $1.3 billion in fiscal 1988 by reimbursing providers more slowly. The Omnibus Budget Reconciliation Act of 1986 (OBRA) established maximum time periods in which most Medicare claims must be paid. The Administration plans to slow down payments so that the legislative limits become a minimum as well as a maximum. CBO budget estimates and this review does not include this slowdown because it is inconsistent with Congressional intent. The President also proposes to set a permanent reimbursement schedule of 30 days to all providers. While these delays would not affect total reimbursements to providers, it would cause cash-flow problems, which could be a very significant administrative burden for small providers and high-volume Medicare providers.

--**ESRD.**--Would repeal the 1986 OBRA provision which placed a floor on reimbursement rates to facilities which perform dialysis on End Stage Renal Disease patients. This proposal would enable the Administration to cut current reimbursement rates, thus providing further incentives for clinics to reuse dialysis equipment more times than is currently practiced. Health concerns surrounding multiple reuse of dialysis devices have been raised by the Senate Special Committee on Aging.

Laboratory Tests.--Would lower payments for clinical laboratory services, reduce charges for durable medical equipment, and eliminate return-on-equity allowances for Medicare payments to skilled nursing facilities and out-patient hospital departments. Savings estimates for these proposals total $1.1 billion over five years, almost 70 percent of which comes from the reduction in laboratory services reimbursement.

MEDICAID

The Program

In 1965, the Congress enacted the Medicaid program to provide matching funds to States to finance health insurance for the poor, including supplemental insurance for the elderly poor who qualify for Medicare. The Federal Government matches State administrative costs through the Health Care Financing Administration (HCFA), which also administers the Medicare program. Under current law, Medicaid grants match all qualifying State payments for all eligible beneficiaries under the program, and no limit is placed on Federal payments.

In fiscal 1986, Medicaid paid $25 billion in Federal benefits, and is estimated to pay $26.7 billion in fiscal 1987. In 1987, States are expected to finance health care for 23.6 million poor Americans, 3.5 million million of which are elderly. Five percent of Federal Medicaid expenditures reimburse States for administrative expenses. Medicaid pays for approximately 13 percent of all health care costs for the elderly. Most of this amount represents expenditures for nursing home care.

Administration's Proposed Fiscal Year 1988 Budget

The President has proposed a number of changes in Medicaid that would reduce spending by at least $1.3 billion in fiscal 1988 and $21.6 billion over the next five fiscal years. By turning it from a program which pays the medical bills of all those who qualify to one which is essentially a block grant program to the States, the Administration continues to propose changes which would alter the very nature of the Medicaid program. Should these proposals be enacted, States would be able to provide care only to the extent of their own available funds and priorities.

- **--Benefit Cap.**--Would set a ceiling on Federal payments of $26.9 billion in fiscal 1988 and would index the payments to the medical services component of the Consumer Price Index (MCPI) in subsequent years. Federal payments to States would continue to match State expenditures, but only up to each State's funding limit for that year. This proposal would save $1.0 billion in fiscal 1988, but threatens to jeopardize access to needed medical care for many low-income Americans.

- **--Eliminate enhanced matching rates.**--Would cut currently enhanced matching rates for administrative and enforcement functions under Medicaid. Existing law provides for reimbursement to the States for these activities at 75 percent of the State's costs. The President proposes to reduce the rate to 50 percent for a $2.3 billion savings over five years. This proposal contradicts recommendations, from such bodies as the Institute of Medicine (National Academy of Science), which call for providing full Federal funding for State's nursing home inspections.

- **--Encourage expansion of prepaid health programs.**--Would encourage States to expand use of organizations, such as health maintenance organizations (HMOs), that provide health care on a fixed, prepaid basis. Budget savings in this area are unlikely because States would not be permitted to obtain savings beyond the proposed cap.

- **--Increase Medicare premium paid by Medicaid.**--This proposal, outlined previously in the Medicare budget analysis, would increase Medicaid costs by about $650 million in fiscal 1988. However, should the proposed Medicaid cap be enacted, the higher Medicare premiums would have to be absorbed entirely by the States.

NATIONAL INSTITUTES OF HEALTH

The Programs

The National Institutes of Health (NIH), marking the 100th anniversary of its establishment this year, conducts and supports research aimed at improving the health of all Americans. It is the principal biomedical research agency of the Federal Government. Eight of the Institutes study areas of particular importance to the nation's older population.

A. National Institute on Aging

The National Institute on Aging (NIA) conducts and supports biomedical research aimed at easing or eliminating the physical, psychological and social problems which affect older Americans. Areas of biomedical and clinical research include studies on the genetic determinants of aging; the diagnosis and treatment of Alzheimer's disease and osteoporosis, the impact of nutrition on aging; drug use by the elderly; sleep disorders; and depression. All NIA research benefits older Americans.

B. National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors research relating to the cause, prevention, detection and treatment of cancer. Of all new cancer cases reported, over half involve elderly victims, and over 60 percent of all persons who die of cancer each year are older Americans.

C. National Heart, Lung and Blood Institute

The National Heart, Lung and Blood Institute (NHL&BI) focuses its attention on diseases of the heart, blood vessels, blood, lungs and on the management of blood resources. NHL&BI studies three of the top ten chronic conditions afflicting the elderly -- hypertension, heart conditions and arteriosclerosis. 25 percent of all senior citizens suffer from a chronic heart condition, nearly 40 percent suffer from hypertension, and 8 percent from arteriosclerosis.

D. National Institute of Dental Research

The National Institute of Dental Research (NIDR) is the leading Federal agency supporting research and research training on oral health and disease. The major aims of the Institute's research program are the preservation of the oral tissues and the prevention of tooth loss from the chief dental diseases -- dental caries and periodontal diseases -- so that human teeth and gums can last a lifetime. Improving the oral health of older people is the focus of a collaborative project between the NIA, the NIDR and the Veterans Administration. The research agenda has identified critical areas such as the relationships between oral health and nutritional status, and chronic pain in older Americans.

E. National Institute of Diabetes and Digestive and Kidney Disease

The National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) conducts and supports research in areas of particular concern to the elderly. For example, its research on diabetes, a common but usually non-fatal disease, brings hope to the nearly 10 percent of senior citizens who are known to be diabetic.

F. National Institute of Neurological and Communicative Disorders and Stroke

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) supports and conducts research and research training to further the understanding of the normal and disordered function of the nervous system, (including the brain, spinal cord, and peripheral nerves), muscles, hearing and human communication. The majority of the disorders studied are characterized by long-term disabilities which markedly impair the quality of life. Research on disorders of particular interest to the elderly include: stroke, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis and the dementias including Alzheimer's disease.

G. National Eye Institute

The National Eye Institute (NEI) conducts and supports research to develop new diagnostic measures, treatments and cures for blinding eye diseases and visual disorders. Eye disorders that are common in older adults and are actively being studied by the NEI include aging-related maculopathy, cataract and glaucoma.

H. National Institute of Arthritis, Musculoskeletal and Skin Diseases

Similar to the NIDDK, the National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMSD) conducts and supports research on diseases which, although not often fatal, can cause great hardships for many elderly in the form of increased medical bills and loss of mobility and productivity. Varying arthritic conditions and osteoporosis are top prioritities for the NIAMSD. This is particularly important to the almost 50 percent of all persons over the age of 65 who suffer some degree of chronic arthritis.

Administration's Proposed Fiscal Year 1988 Budget

The President proposed to reduce significantly the federal commitment to biomedical research by funding NIH at $971 million below current services levels for fiscal 1988. Of particular concern is the budget request to fund 700 fewer research grants than Congress appropriated money to support by deferring or reappropriating $339 million of 1987 appropriations from fiscal 1987 to fiscal 1988. However, there has been discussion that the Administrtion may withdraw this deferral proposal.

The president also proposes to alter significantly how research grants are funded. Currently, the Congress funds multi-year NIH grant awards one year at a time. Beginning in fiscal 1988, the Administration requests that the Congress provide an additional advance $2.7 billion appropriation for the future-year expenses of new grants awarded in 1988. Outlays would not be affected by this change and it is important to recognize that this increased appropriation does not represent an increased commitment to biomedical research.

Some of the ways that the proposed cut in the NIH budget will be implemented:

--**NIA**.--Proposes to defer $11 million of the funds Congress appropriated in fiscal 1987 to the fiscal 1988 budget. At this level, 26 fewer grants would be funded in fiscal 1987. The Administration claims that the fiscal 1988 request will support all ongoing research centers, including the Alzheimer's Disease Research Centers, at approximately the same levels as in the fiscal 1987 current estimate. However, if deferral proposal is not accepted by the Congress, the

Administration's funding level for NIA FY 1988 research would be $156 million, approximately $21 million less than the FY 1987 appropriation. If Congress does not act to increase funding, the numbers of biomedical research grants would be greatly reduced.

--**NCI.**--Proposes to defer $64 million of the funds Congress appropriated in fiscal 1987 to the fiscal 1988 budget. At this level, 116 fewer grants would be funded in fiscal 1987. The Administration claims that funding for all other programs would be approximately equal to the fiscal 1987 levels except that the construction/renovation program will not be funded and there will be an increase of $23.2 million for AIDS research. If the proposed reappropriation is not accepted, however, the Administration's funding level for NCI FY 1988 research would be $1.3 billion, approximately $100 million less than the FY 1987 appropriation. If additional funds are not granted, the number of cancer research grants will be greatly reduced.

--**NHL&BI.**--Proposes to defer $56.6 million of the funds Congress appropriated in fiscal 1987 to the fiscal 1988 budget. At this level, 109 fewer grants would be funded in fiscal 1987. The budget request provides an increase of $2 million for AIDS research. However, should the proposed deferral not be accepted by Congress, the Administration's funding level for NHL&BI FY 1988 research would be $821.9 million, approximately $109 million less than the FY 1987 appropriation.

--**NDR.**--Proposes to defer $5.5 million from fiscal 1987 to fiscal 1988. At this level, 19 fewer grants would be funded in FY 1987.

--**NIDDK.**--The deferral proposal would carry over $35.4 million from fiscal 1987 to 1988. At this level, 77 fewer grants would be funded in 1987. However, if the deferral is not accepted by the Congress, the Administration's funding level for NIDDK FY 1988 research would be $440.5 million, approxmately $70 million less than the FY 1987 appropriation.

--**NINCDS.**--Proposes to defer $35 million from fiscal 1987 to fiscal 1988. At this level, 75 fewer grants would be funded in FY 1987.

--**NEI.**--Proposes to defer $15.2 million from fiscal 1987 to fiscal 1988. At this level, 34 fewer grants would be funded in FY 1987.

--**NIAMSD.**--By deferring $9 million to the fiscal 1988 budget, the Administration proposal would reduce the number of funded grants in fiscal 1987 by 10. However, if the proposed deferral is not accepted by Congress, the Administration's funding level for NIAMSD FY 1988 research would be $123 million, approximately $15.7 million less than the FY 1987 funding level.

VETERANS HEALTH

The Program

The Veterans Administration (VA) provides a wide range of services to men and women who have given past service in the Armed Forces. The VA provides health care services in 172 VA medical centers, 117 nursing homes, and 229 outpatient facilities. It also contracts with private and State facilities to provide veterans with hospitalization and nursing home care.

As a result of "The Veterans Health Care Amendments of 1986" (P.L. 99-272), eligibility requirements for VA medical care were changed. This new law established three categories of eligibility:

A. Service-disabled veterans, former prisoners of war and veterans exposed to certain toxic substances and radiation, veterans of wars prior to World War II and those receiving VA pensions, as well as those nonservice-disabled veterans with annual earnings of less than $18,000 (with one dependent; $15,000 for a single veteran).

B. Nonservice-disabled veterans earning between $18,000 and $25,000 per year (with one dependent; between $15,000 and $20,000 for a single veteran).

C. Nonservice-disabled veterans with earnings above Category B levels.

The VA has an obligation to provide hospital care and may provide outpatient and nursing care to veterans in Category A. The VA may provide hospital, outpatient and nursing care, within existing resources, to veterans in Categories B and C, providing that veterans in Category C agree to make a copayment.

The projected increase in the elderly population is reflected in the veteran population. The number of veterans over the age of 65 was 4.6 million as of September, 1985. It is predicted that this number will increase to 7.2 million by 1991, and will peak at 8.9 million in 1999. In 1991, 60 percent of all males over the age of 65 will be veterans, and of the projected 8.9 million veterans in 1999, 3.8 million will be age 75 or older.

Administration's Proposed Fiscal Year 1988 Budget

The President requests a budget outlay of $9.8 billion for veterans medical care. This amount, is $348 million above the FY 1987 level. The increased funding request can be attributed largely to higher payroll costs, primarily a result of the new Federal Employees Retirement System. This funding will provide for treatment of an estimated 1.45 million inpatients and an estimated 20.4 million outpatient visits. Highlights of the President's proposal include:

--$75 million rescission eliminating funding that is no longer needed as a result of the new eligibility requirements under P.L. 99-272. This funding would otherwise be used during the last five months of FY 1987 for hospital, outpatient, VA nursing and community nursing services paid for by the VA for care of higher-income, nonservice-disabled veterans, who are financially able to provide for their own health care. It is clear that the rescission proposal will not gain congressional approval.

--A decrease of $178 million and 4,400 Full Time Employment Equivalents (FTEE) over the FY 1987 level for program and management activities. Of this decrease, over $92 million will be saved under P.L. 99-272 and an additional $58 million will be saved with a projected one percent increase in productivity.

--Conversion of 282 hospital beds to nursing care beds.

--The extended care program will be increased by $32.9 million and 584 FTEE, including an increase of $20.5 million for VA nursing home care.

FOOD AND DRUG ADMINISTRATION

The Program

The Food and Drug Administration (FDA) administers and enforces laws concerning dangerous, misbranded, and and adulterated foods, drugs, human biologics, medical devices, cosmetics and man-made sources of radiation. FDA program outlays are estimated to total $447 million in FY 1987.

Older Americans are the Nation's largest consumers of drugs, and often need special "diabetic" or "low sodium" foods. The elderly depend on the actions of the FDA's regulatory and enforcement authority to remain healthy. In recent years, the FDA has given increased attention to programs developed for the elderly.

Administration's Proposed Fiscal Year 1988 Budget

The President's spending authority request for the FDA in fiscal 1988 is $483 million. To reach this level, the Administration resubmits its often-rejected user fee proposal.

--**User Fees.**--Proposes to obtain additional revenue by charging user fees for product review by the FDA. This proposal would produce an estimated $34 million. However, if rejected, $29 million more will be required to maintain current services levels in FY 1988. Further, additional funds would be required to pay for new Administration staffing and retiree financing proposals.

FEDERAL EMPLOYEES HEALTH BENEFITS

The Program

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for approximately 8 million Federal Government employees, retirees and their dependents. Under the program, employees and retirees are offered a choice of different health plans which have varying levels of benefits and premiums. The premium rates for FEHB plans are paid through premium contributions by the Federal Government and by the enrolled employees and retirees.

Administration's Proposed Fiscal Year 1988 Budget

The President's budget request proposes two formula changes which would reduce the Federal Government's share of financing the FEHB program by approximately $500 million.

--**Formula tied to average premium of all FEHB plans.**--Would tie the Government's share of costs to the average of premiums in all FEHB plans, rather than to the average of premiums in the six largest, high option plans -- as specified under current law. The formula also would be weighted by the distribution of employees among all plans. This proposal would lower the Government's share of health insurance costs and shift these costs to Federal employees.

--**Increase D.C. and Postal Service contribution.**--Proposes that the U.S. Postal Service and the District of Columbia pay the government's share for postal and Distrcit retirees' health premiums. FEHB payments would be lowered by $400 million in fiscal 1988 and by about $2.7 billion over the next five years.

INDIAN HEALTH SERVICE

The Program

The Indian Health Service (IHS) is the component of the Department of Health and Human Services charged with administering the principal Federal health programs for approximately one million American Indian and Alaska Native people living on or near Federal Indian reservations or in traditional Indian country, such as Alaska and Oklahoma. Under the legislative authority of the Indian Health Care Improvement Act (P.L. 94-437), the IHS is charged with the responsibility of raising the health status of Indian and Alaska Native people to the highest possible level. Despite the efforts of IHS, Indian peole continue to suffer the lowest health status of all American citizens.

Administration's Proposed Fiscal Year 1988 Budget

Once again, the President proposes to cut $126 million in fiscal 1988 and $1 billion over the five year budget period from funding for Indian health services and construction of health care facilities. The Administration states these cuts represent a phasing down of these two programs and offers the disputable claim that community or other governmental forms of support will begin to replace this loss of Federal support.

SOCIAL SECURITY

The Program

Established in 1935, the Social Security program provides income for eligible workers and their families when the worker retires, becomes severely disabled, or dies. The benefits are funded through FICA (Federal Insurance Contributions Act), SECA (Self-Employed Contributions Act) payroll deductions, income taxes on benefit payments, certain transfers from general revenues, and interest on invested balances. The program consists of Old Age and Survivors Insurance (OASI) and Disability Insurance (DI), and eligibility is determined by the number of quarters a worker has contributed to the program.

Social Security is the largest Federal entitlement program, and accounts for approximately 20 percent of annual Federal spending. The program accounts for 55 percent of all Federal spending on the elderly. In September 1986, almost 37.5 million persons received Social Security benefits, and of those, 61 percent, or 22.8 million were retired workers. Disabled workers numbered 2.7 million and accounted for 7 percent of the total. Widows, widowers, surviving children, and other dependents made up the balance of the recipients. The average monthly benefit check for both groups was $482 in 1986.

Administration's Proposed Fiscal Year 1988 Budget

Benefits

The President's fiscal year 1988 budget calls for no reduction in benefits for those receiving Social Security. The 1987 cost-of-living adjustment (COLA) of 1.3 percent is being paid with checks issued in January 1987 and the 1988 COLA will be given regardless of the 1988 inflation rate. However, the budget does propose a significant cut in staffing at the Social Security Administration (SSA).

Staff Cuts

The Administration's Budget would require staff cuts of 2,454 in FY88 in addition to the 3,695 being reduced this year. This is the result of the Administration's announced intention in 1985 to eliminate 17,000 staff by 1990. These cuts come when there will be greater demands on SSA due to the increasing aging population, the new Immigration and Tax Reform laws. (SSA estimates the two new laws alone will require an additional 2,500 work years; CBO estimates 5,000 work years).

The rationale for the staff cuts and accompanying closing of offices is that SSA is modernizing its computers and administrative procedures. However, a December 1986 GAO Report is critical of this attempt. SSA has indefinitely deferred the modernization of its computer software for 94 percent of its transactions for beneficiaries; the completion date for the remaining portion of the software development plan is unknown; and pilot testing of the new software systems has not included an evaluation of its impact on service to the public.

Congress and aging advocacy organizations have raised many concerns about the effect of a deep staff cut on the quality of service provided to recipients. Despite these concerns, SSA still has not developed and implemented quality standards which measures what constitutes adequate beneficiary service.

SUPPLEMENTAL SECURITY INCOME

The Program

The Supplemental Security Income Program (SSI), enacted in 1972, provides income to the Nation's low-income elderly, blind, and disabled, and is financed through general revenues. The program is administered by the Social Security Administration. Unlike Social Security, SSI recipients need not qualify for benefits with work quarters or payroll deductions. Beneficiaries are subject to a means test, that is, eligibility is based upon income levels and asset availability.

In many cases, SSI benefits supplement income from other sources, including Social Security benefits. Monthly checks are issued to bring recipients' income to a level of $340 per month for individuals and $510 per month for couples. States have the option of supplementing SSI benefits. Slightly more than 46 percent of all SSI recipients are 65 or older. A 1985 report estimated that the average monthly SSI check received by elderly beneficiaries was $164, while the averages for the blind ($274) and disabled ($262) were significantly higher. This discrepancy is probably due to the fact that many elderly SSI recipients qualify for some measure of Social Security benefits.

Administration's Proposed Fiscal Year 1988 Budget

The SSI program is administered by the Social Security Administration (SSA). The proposed budget would require staff cuts of 2,454 in FY88 in the Administration's continuing effort to cut at least 17,000 by 1990. These cuts would place an ever-increasing burden on SSA due to the increasing aging population and the new Immigration and Tax Reform laws.

BLACK LUNG

The Programs

Income maintenance for disabled coal miners and their dependents is provided through two separate programs.

Black Lung Part B:

Black Lung Part B provides benefits to disabled coal miners and their dependents and survivors who filed claims before July 1973. Funds are appropriated from general revenues and administered by the Social Security Administration (SSA). Currently, nearly 300,000 annuitants and survivors, of whom approximately 188,000 are elderly, benefit from the program.

Black Lung Part C:

Black Lung Part C provides income and medical benefits to disabled coal miners and their dependents or survivors who filed claims after June 30, 1973, or who had failed to qualify earlier under Part B. Black Lung Part C is administered by the Department of Labor. It was enacted to shift the burden of compensation from the Federal Government to the coal industry. Under Part C, an effected coal miner leaving work prior to 1970 is eligible for Black Lung Disability Trust Fund benefits. Money for the Fund comes from an excise tax on coal.

Those retiring after 1969 are not eligible for Trust Fund benefits. Instead, the Labor Department attempts to identify the responsible employer. This employer is then liable for damages.

Administration's Proposed Fiscal Year 1988 Budget

Benefits in the Black Lung and Special Benefits for Disabled Coal Miners programs are indexed to changes in federal pay.

--**COLA Proposals.**--The Administration proposes to freeze the COLAs for these programs in FY88 and to limit them to half of federal pay raises in the following years. CBO estimates this would save $29 million in FY88 and approximately $500 million over the five year period from FY88-92.

--**Coal Tax.**--The Administration also proposes an increase in the coal tax, which provides a source of funds for the Black Lung program. CBO estimates that this would increase revenues on a unified budget basis by $1.3 billion over the FY88-92 period.

--**Education Benefits.**--The Administration proposes phasing out financial assistance for higher education for dependent children of those drawing Black Lung benefits. At present they are eligible for an amount equal to half the benefit being drawn by their disabled parent. Each additional child is eligible for an amount equal to 25 percent of that benefit.

VETERANS: COMPENSATION AND PENSIONS

The Programs

Compensation is paid to veterans for disabilities incurred in or aggravated during active military service. Death and Indemnity Compensation (DIC) is paid to survivors of service persons or veterans whose death occurred while on active duty or as a result of service-connected disabilities. The Administration has proposed a 3.5 percent COLA increase for FY88.

Veterans' pensions are awarded on the basis of service, disability, and level of income. Pensioners receive annual Cost Of Living Adjustments (COLAs) comparable to Social Security COLAs.

Administration's Proposed Fiscal Year 1988 Budget

Veteran's Administration:

Under the Administration's proposed FY88 budget, the Veterans Administration would receive modest funding reductions. While in FY87 the Administration received $26.3 billion in appropriations, it has requested budget authority of $27.6 billion for FY88. This represents a slight decrease in real terms; but the decrease is primarily the result of declining caseloads in entitlement programs.

Home Loan Guarantee Program:

The Administration's FY88 budget for veterans' benefits and services proposes significant changes in the home loan guaranty program of the Veterans Administration (VA). Loan recipients currently pay a standard fee of one percent of their loans. This fee is scheduled to expire this year. While some parties propose extending the present fee, the Administration would raise it to 2.5 percent.

CIVIL SERVICE RETIREMENT

The Civil Service Retirement System (CSRS) is funded through a combination of payroll deductions and general revenues. It covers 2.75 million current employees. Benefits are pegged to earnings history and years of service to the Government. In FY87, an estimated $25.5 billion will be paid to 2 million retirees and survivors, approximately 65 percent of whom are senior citizens.

Administration's Proposed Fiscal Year 1988 Budget

The Administration's FY88 budget proposes two changes in the CSRS:

- **--COLA Changes.**--Under the first proposal, COLAs equal to the full CPI would be paid only when that increase is 2 percent or less. When the CPI increase is between 2 and 3 percent, the COLA would be 2 percent. If at any time the CPI increase is over 3 percent, the COLA would be the CPI minus 1 percentage point. The Administration estimates that this change would save $183 million in 1988 and $1.4 billion over the 3-year period FY88-90.

- **--Repeal Federal employee withdrawal provision.**--The second proposal would repeal a new provision allowing retiring Federal workers to withdraw their contributions into the retirement system in exchange for a reduced annuity. Although this provision is cost-neutral in the long run, the Administration estimates repealing it would save an additional $1.3 billion in FY88 and $3.7 billion for the 3-year period FY 1988-1990.

MILITARY RETIREMENT

Approximately 12.3 million retired officers, enlisted personnel, and their beneficiaries received more than $18 billion in annuity pay during FY86. Only about 20 percent of participants are elderly because military personnel qualify for retirement after 20 years of service, regardless of age.

Administration's Proposed Fiscal Year 1988 Budget

The Military Retirement program, like the Civil Service Retirement System, can only be subjected to cuts in the COLA. For FY88 however, no COLA limitations are proposed for military retirement. Military pensions will continue to be fully indexed, regardless of the rate of inflation, and, again, those 62 or over will receive social security for their military service, also fully indexed.

- **--Indexing Changes.**--As with CSRS, indexing changes are proposed for the military retirement system. They include the restriction of military retirement COLAs to the CPI minus 1 percentage point, but would not apply to anyone retiring before the year 2006.

RAILROAD RETIREMENT

The Program

The Railroad Retirement program provides retirement income for former railroad employees and their families when the employee retires, becomes disabled, or dies. The Railroad Retirement Board issued benefit checks totaling nearly $6.3 billion to about one million annuitants and survivors in FY86 (estimated to be $6.5 billion in FY87).

The benefit is divided into two parts or tiers plus a supplemental annuity to workers with long railroad service and a dual, or windfall, benefit for workers who became vested for Social Security benefits prior to 1975. Tier I is roughly equivalent to Social Security benefits. Tier II is equivalent to a private pension. The supplemental annuity is given to workers with the equivalent of 25 or more years of railroad service. Currently, about 20 percent of railroad retirees receive a supplemental annuity. However, this benefit is being phased out as a result of the Railroad Retirement Solvency Act of 1983.

Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of dual vested or so-called windfall benefits, which are paid for through general revenues from a special account.

Administration's Proposed Fiscal Year 1988 Budget

The Administration proposed budget will:

--**COLA Freeze**--Proposes to freeze the 1988 Cost Of Living Adjustment for rail industry pensions.

--**Increase Tier II tax rate**--Proposes to "protect the solvency of the fund" by increasing the Tier II tax rate by 1.5 percent. As Tier II is roughly the equivalent of a collectively bargained pension benefit, both labor and board representatives have requested that they be allowed to discuss this increase and work out the details between labor and management before any sudden changes are made.

--**Financing the Federal windfall subsidy payment**--Proposes to have the rail sector finance 25 percent of the Federal windfall subsidy payment. The rail sector financing of 25 of the Federal windfall subsidy payment runs contrary to the Railroad Retirement Act of 1974. The 1974 Act provides that the phase out of windfall dual benefits should be paid through appropriations from the general fund and not by the rail sector.

PENSION BENEFITS GUARANTY CORPORATION

The Program

The Pension Benefits Guaranty Corporation (PBGC) is a wholly owned Government corporation. Operating under the Department of Labor, this entity administers programs of mandatory termination insurance to prevent loss of pension benefits under covered private, defined benefit pension plans if plans terminate or if multi-employer plans are unable to pay benefits. Terminated plans are taken over by the Corporation. The Corporation assumes control of their assets, administers them in a trust fund held in a private bank, and takes responsibility for paying benefits. The Corporation also provides repayable assistance to insolvent multi-employer plans when necessary to pay benefits and to forestall termination and subsequent Corporation responsibility to pay benefits. All benefits paid through PBGC's insurance program are funded exclusively through employer-paid premiums.

Despite the tripling of the premium last year, which increases income to the PBGC by approximately $200 million annually, the PBGC is still in a precarious financial position, particularly due to the recent termination of LTV Corporation's pension plans--the estimated 1988 benefit payments for LTV alone are approximately $400 million, $100 million more than premium income from all plan participants. In 1989, under current law, the PBGC will be unable to meet its obligations from current income and revolving fund balances and will be forced to deplete assets in order to pay benefits.

Administration's Proposed Fiscal Year 1988 Budget

The Administration proposes a change in the PBGC's premium charges from a flat premium of $8.50 per pension plan participant to a premium that would increase according to the unfunded liability in a private employer plan. Pension plans would pay a minimum of $8.50 per participant plus an additional amount for every $1,000 per participant of unfunded liability. The new structure would increase the average premium to an estimated $20 per plan participant and would reduce outlays by approximately $1.3 billion over the projection period.

The Administration is expected to introduce an amendment to ERISA that will make it easier for companies to take surplus money out of pension funds and use it for their own benefit. The Administration's rationale is that this proposal will mitigate or avoid losses incurred by plan participants and the PBGC. However, labor unions, consumer groups and many organizations representing older persons strongly believe that pension plans would be weakened by any change permitting employers to withdraw money for their own purposes and actually put new burdens on the PBGC in the future if companies experience economic difficulties.

FOOD STAMPS

The Program

The Food Stamp program was begun in 1964 to alleviate hunger and malnutrition among low income persons. Eligible households receive monthly allotments of stamps, based on income and household size, to finance food purchases. The level of benefits is based on USDA's Thrifty Food Plan which estimates how much it would cost a household that shops economically to meet its nutritional needs. A household is eligible for food stamps to the extent that 30 percent of household income falls below the applicable Thrifty Food Plan level. In FY 1986 the maximum food stamp benefit to a one person household was $81 and for a two person household the maximum was $149 a month. The plan is adjusted upward annually for changes in the cost-of-living.

The Federal Government bears the cost of all food stamp benefits and shares with the States and localities 50 percent of most administrative costs. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At the State and local levels the Food Stamp Program is administered by State welfare departments.

Administration's Proposed Fiscal Year 1988 Budget

The Administration's FY88 budget for the Food Stamp program and Puerto Rico's nutrition assistance program proposes to hold Federal costs to $12.5 billion, almost $600 million below the $13.1 billion that would be required under existing law and current administrative practices. The Administration's proposals include:

--**Savings from erroneous benefit payments.**-- The overwhelming majority of the "savings" proposed for FY88 represent collections of "fiscal sanctions" imposed on States for high rates of erroneous benefit payments. Some $233 million in sanctions for erroneous payments prior to FY88 are assumed as collected in FY88. In addition, the Administration recommends that legislation be enacted to increase sanctions imposed for errors in FY88 and beyond to allow the Federal Government to collect these sanctions in advance, based on estimated State error rates; this is expected to reduce the need for Federal outlays by $258 million.

--**Coordination of benefits.**--Would lower Food Stamp benefits for households which receive energy assistance from the Low Income Home Energy Assistance Program and/or the Job Training Partnership Act. For example, any LIHEAP funds would be subtracted from an individual's "shelter costs." In practice, this proposal would increase the stated income of a person and, therefore, their perceived need for food stamp assistance would be less because their "discretionary income" would be higher. This proposal strikes particularly hard at the elderly who represent over 33 percent of households with LIHEAP assistance. It is estimated that $57 million in outlays would be saved from participants of the LIHEAP program and $10 million from JPTA participants.

Administration

The Budget proposes to reduce federal funding for certain administrative costs--a 4 percent reduction. States are not required to contribute funds above those needed to match Federal contributions. Thus, the reduction in administrative costs will, in some States, constitute a "double hit."

FOOD PROGRAMS

The Program

The Department of Agriculture(USDA) administers two food programs which benefit senior citizens. The Nutrition Program for the Elderly, a part of USDA's Food Donation's Programs, is authorized under the Older Americans Act to help meet the nutritional needs of the elderly. This program works with the Department of Health and Human Services to provide commodities and cash to senior centers and other locations where congregate meals are served. In 1987, appropriations helped serve over 227 million meals.

The Elderly Feeding Pilot Project (EFPP) is a small, but important test program under the larger Commodity Supplemental Food Program (CSFP). EFPP provides direct distribution of USDA surplus commodities to low-income persons 60 years of age and older at centers in three different cities. The Congress appropriated $4.9 million for the operation of this program in Fiscal Year 1987. EFPP is financed through the CSFP, and some funds are provided to the local centers through the Temporary Emergency Food Assistance Program (TEFAP). TEFAP provides funds to States to be used to transport, store, and distribute these Commodity Credit Corporation-donated foods for needy individuals.

Administration's Proposed Fiscal Year 1988 Budget

The Administration's proposed Fiscal Year 1988 budget for the Nutrition Program for the Elderly will remain constant with current law. This represents a slight increase in appropriations from $139.5 million in FY87 to $140.3 million in FY88.

The EFPP has significantly expanded the number of approved individuals and therefore has proposed a dramatic increase in appropriations. The Administration proposes to raise outlays from 4.9 million in FY87 to 10.5 million in FY88.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The Program

Begun in 1980, the Low Income Home Energy Assistance Program (LIHEAP) funds block grants to States to be used for assisting low-income households with their heating and cooling bills, energy-related emergency assistance, and weatherization. The program serves 7.3 million households per year, and of those, approximately 40 percent have at least one member 65 years of age or older. This large percentage of elderly reflects their heightened vulnerability to harm from weather extremes.

Administration's Proposed Fiscal Year 1988 Budget

LIHEAP Funding

The Administration requests $1.2 billion in 1988 outlays for LIHEAP, $600 million below the amount provided for 1987. For future years, projected appropriation requests would remain at $1.2 billion, which could produce further outlay savings amounting to $3.4 billion for the projection period. The rationale given for the reduced appropriation request is that States have received money from settlements on oil overcharges that can be used for this program. The States have received $3.1 billion in settlements to date, and it is estimated that $2 billion more will become available between now and 1992.

While the total funds from these settlements appear to be sufficient to cover the reductions in energy assistance funding, this is misleading because the formula for State distribution of the funds varies significantly. For example, eight States could receive a 100 percent increase in energy funds if their LIHEAP grants were replaced with oil overcharge settlement grants, while 11 States could lose over one-third. Lastly, the rationale for cuts in this program appears to ignore the facts that only one-third of those eligible for the program are able to obtain benefits and funds from the settlements aren't indefinite.

Chapter 3 -- Housing

HOUSING AND URBAN DEVELOPMENT

The Programs

The Department of Housing and Urban Development (HUD) administers five housing programs that benefit the elderly. The most well-known HUD program, **Section 202**, provides direct loans to non-profit organizations for the construction of new housing projects or major rehabilitation of existing housing projects designed specifically for low-income elderly and handicapped persons. Those residing in Section 202 housing are also eligible for Section 8 housing assistance, which pays for the difference between the established rent and the tenant's required contribution toward that rent, which is 30 percent of his or her income. **Approximately 90 percent of those living in Section 202 housing are elderly.**

The **Congregate Housing Services Program** (CHSP) is a HUD program that provides supportive services such as meals, housekeeping and transportation to eligible elderly residents of Section 8, Section 202 or public housing projects. Under CHSP, HUD contracts with local public housing authorities or non-profit organizations to provide these supportive services on the premise that the appropriate use of these services can help frail elderly and handicapped persons to avoid premature institutionalization. Begun in 1979 as a demonstration project, CHSP has served over 2,700 elderly persons in 64 projects. The appropriation for this program in fiscal year 1987 is $3.4 million.

The oldest federal program providing housing for the elderly is the **Low Rent Public Housing** program. It provides direct federal loans to finance the construction, acquisition, and modernization of public and Indian rental housing. Over 1.3 million public housing units provide housing for 3.5 million persons, of whom 27 percent are elderly. The elderly comprise about 6.5 percent of those living in Indian housing.

Under the **Community Development Block Grants** (CDBG) program, HUD makes grants to local governments and states to fund various local community development projects to help low- and moderate-income households. The elderly receive a wide range of benefits from this program. For example, a 1982 Government Accounting Office survey indicated that a large proportion of the housing rehabilitation financed under CDBG is used to repair and weatherize homes owned by low and moderate income elderly. Other CDBG activities that benefit the elderly include social services, improvements in neighborhood facilities, such as senior centers, and the removal of architectural barriers.

The **Section 8** program, created in 1974, was designed to assist those with incomes too high for public housing, but who cannot afford to pay the market rent. There are three parts to the program: existing housing, new construction and substantial rehabilitation. Since 1983, however, the only new Section 8 construction has been in conjunction with the Section 202 program. Over 40 percent of all Section 8 units are occupied by older persons.

Administration's Proposed Fiscal Year 1988 Budget

The President's proposed FY 88 budget for HUD would eliminate all new construction by the end of FY 88, and substantially reduce or eliminate funding for modernization of existing housing. The President would replace these programs with rental vouchers, emphasizing the use of existing housing, and/or privately-held housing. Specific proposals include:

Section 202: For fiscal year 1987, Congress appropriated $593 million to finance the construction of 12,000 units. The President would defer funding for 2,000 units ($91 million) to FY 88, reducing the FY 88 funding to $502 million, or 10,000 units. The President requests no new funding for this program, and would eliminate it after FY 88.

CHSP: The President repeats his request for no new funding for this program.

Public Housing: The President's proposal would eliminate new construction and rehabilitation of public housing in FY88. The President would also defer $437 million of the $1.4 billion FY 87 modernization budget to FY 88, resulting in a funding level of approximately $1 billion for each year. It would also extend any unused balance of FY 87 funds for operating, maintaining, and modernizing public housing projects into FY 88. In addition, the President's proposal reduces the level of Indian housing units from 2,500 to 1,000.

CDBG: The President would rescind $375 million from the FY 87 appropriation, leaving $2.62 billion. That same level is proposed for FY 88.

Section 8: The President's budget would reduce the number of Section 8 moderate rehabilitation units by one-third: 7,500 to 5,000 units. The $239 million this reduction represents would be rescinded, and no new funding is requested for moderate rehabilitation for FY 88.

FARMERS HOME ADMINISTRATION

The Programs

The Farmers Home Administration (FmHA) provides loans and grants to residents of rural areas. Many of FmHA's programs deal directly with the agricultural industry; however, several involve rural housing. Three FmHA programs are of importance to the elderly, one-third of whom live in rural areas.

The **Section 502** program provides loans for the repair or purchase of new or existing single-family housing for low-income rural residents. Borrowers must be unable to obtain reasonable credit terms elsewhere, and the homes must be modest in cost and design, and located in rural areas serviced by FmHA. Since its inception in 1950 through the end of FY 85, approximately 1.9 million homes have been financed through this program. The elderly participate in this program, although data is not available as to the extent.

The **Section 504** program provides loans to very low-income households who own housing in rural areas who do not have sufficient income to qualify for a Section 502 loan. The elderly do participate in this program, but data is not available as to the extent. However, Section 504 rural housing grants are designed to help very low-income homeowners 62 years of age and older who do not qualify for conventional loans.

Section 515 is a rental subsidy programs, under which loans are made to appropriate sponsors at subsidized rates, which can reduce the mortgage interest rate to one percent.

Administration's Proposed Fiscal Year 1988 Budget

For fiscal year 1988, the President's budget requests a rescission of over $1.5 billion in the $2.25 billion FY 87 appropriation for FmHA's housing programs. All FmHA rural housing and development loan and grant programs would be terminated by the end of FY 88, and replaced with 20,000 vouchers. Specific proposals include:

Section 502: The President proposes to rescind $1 billion of the $1.3 billion FY 87 appropriation, reducing it to $300 million; this would reduce the number of units from 28,700 to 7,000.

Section 504: The President proposes to rescind $8.6 million of the FY 87 appropriation of $11.4 million for Section 504 loans, reducing the appropriation to $2.8 million, and the number of units from approximately 3200 to 800. The Section 504 grants program FY 87 appropriation would be reduced from $12.5 million to $3.1 million, and the number of units from 2500 to 600.

Section 515: The President proposes to rescind $500 million of the FY 87 appropriation of $669.9 million, leaving an appropriation of $166.9 million. This would reduce the number of units from 21,200 to 5,200.

SUMMARY

Since 1980, federal budget authority for HUD-assisted low income housing has been cut by over two-thirds; FmHA rural housing programs have been cut by over half. Last year, Congress rejected the President's proposals to terminate nearly all federal housing programs except vouchers, although it increased the proportion of housing assistance represented by vouchers. For FY 88, as in the past, the President proposes to eliminate almost all programs that build, rehabilitate, or modernize housing for low and moderate income Americans, and replace them with vouchers. The issue regarding whether the federal government should be involved in the construction of new housing can be debated. In fact, the Administration supports its contention that the federal government should not be involved in new construction by emphasizing the use of existing housing. However, at the same time, the Administration proposes to eliminate most rehabilitation and modernization of existing housing. If nothing else, this approach is an unsound investment strategy.

The FY 87 budget for HUD-assisted housing would be cut by $600 million, leaving a level of $7.2 billion. For FY 88, $3.9 billion is being requested, a 50 percent cut from the current FY 87 budget. About 100,000 vouchers (79,000 through HUD and 20,000 through FmHA) would be provided under the President's proposal. In comparison, this year's allocation of almost 170,000 new units represents a mix of vouchers, public and Indian housing, Section 202 housing, Section 8 rent subsidies and FmHA rural housing development.

HOME WEATHERIZATION

The Program

As a result of rising fuel costs in the early 1970's, Congress enacted the Department of Energy Home Weatherization program in 1976. This program is designed to provide persons with incomes 125 percent of the poverty line and below with assistance in improving the energy efficiency of their homes. That figure, however, is a ceiling, and individual states may elect to make the income eligibility requirements more stringent. In FY 87, approximately $161 million will go to state and local governments to provide weatherization assistance. Similar to the Low Income Home Energy Assistance Program, discussed above, this program gives priority to elderly and handicapped households.

Administration's Proposed Fiscal Year 1988 Budget

The President repeats last year's request for no new funding for this program. However, as the program has a slow spendout rate, the President's request, if honored by Congress, will not abruptly end the Weatherization program. The Administration takes the position that responsibility for providing these services rests with the States, and expect funds made available to States through settlement of petroleum pricing violation cases to pay for State weatherization programs.

Chapter 4.--Services

OLDER AMERICANS ACT PROGRAMS

The Programs

Older Americans Act (OAA) programs are funded through the Administration on Aging, which is located within the Office of Human Development Services of the Department of Health and Human Services (DHHS). OAA programs include, among others, transportation, outreach, congregate and home-delivered meals, adult day care, legal services, telephone reassurance, and long-term care (nursing home) ombudsman programs. Seniors depend on these and other OAA programs for a variety of essential services, many of which help maintain them in their homes and avoid unnecessary institutionalization. An estimated 9.3 million seniors will participate in OAA programs in 1987, and of those, 3.9 million will be low income participants. Congress appropriated a total of $1.2 billion for all OAA programs (including some discussed at other places in this paper) in fiscal 1987.

Administration's Proposed Fisal Year 1988 Budget

For fiscal 1988, the President's budget requests a generic appropriation of $2.2 billion for the 26 separate discretionary social service activities administered by the Office of Human Development Services (OHDS) at DHHS, including Aging and Children's Services, Native American Programs and Developmental Disabilities Programs.

Although the administration lists aging services as a high priority, this approach leaves many important aging and non-aging programs unprotected from cuts or program shifts at the discretion of the Administration. Also, the budget would transfer half ($12.5 million) the funds for aging research to children's foster care and adoption assistance.

TRANSPORTATION

The Programs

Under Section 16(b)(2) of the Urban Transportation Act, the Urban Mass Transportation Administration (UMTA) provides assistance to States for the transportation of the elderly and handicapped. States apportion the money to a variety of private non-profit organizations which use it to purchase equipment such as vans and small buses with wheelchair lifts. Approximately 1000 organizations receive aid from these funds in any one year. Roughly 3.8 million elderly and handicapped passengers are served by the program each year.

In addition, two other UMTA programs provide grants for public transportation services highly utilized by senior citizens. The Section 18 program provides funds for public transportation services in rural areas. While an average of 12 percent of persons living in these areas are elderly, it is estimated that as much as 50 percent of the ridership in some of the over 1,000 local programs is elderly. As a counterpart to Section 18, the Section 9 program provides grants for local public transportation systems operating in urban areas. The percentage of elderly riders varies, but is generally much higher than the ratio of elderly to the population as a whole in a given urban area.

Administration's Proposed Fiscal Year 1988 Budget

For 1988, the President once again, as in 1987, requests major reductions in overall Urban Mass Transit Administration programs from $3.5 billion to $1.6 billion. Authorizing legislation for the 1987 appropriation has been delayed due to the Service Transportation Act being held up in conference. Under this plan, most UMTA programs will lose substantial funding.

The major exception in the President's 1987 proposed reductions was in the Section 16(b)(2) program. The President proposed increased funding for this program by $4 million over 1986 post-sequester levels.

Although the President proposed funding the Section 16(b)(2) program to provide elderly and handicapped transportation at significantly increased levels in fiscal 1987, seniors would be hurt by his overall plan to reduce UMTA funding by two-thirds. Deep proposed cuts to both urban and rural transportation systems will decrease the mobility of elderly and lessen their ability to remain independent. The elderly would lose some access to transportation services as each program benefiting them will lose an equal percentage of funds.

LEGAL SERVICES

The Program

The Legal Services Corporation (LSC), a nonprofit corporation, funds local legal aid projects. In turn, the local projects provide free legal services in civil matters to persons meeting poverty guidelines. Approximately 13 percent of all Legal Services clients are senior citizens, who receive legal assistance in areas such as government benefits, consumer problems, guardianships, involuntary commitments to an institution, and landlord-tenant disputes.

LSC will receive $305.5 million in Federal outlays for fiscal 1987. If the program continues at current services levels, outlays will total $320 million in fiscal 1988, and reach $376 million by fiscal 1991. Local legal aid offices receive approximately 88 percent of their funding from the Federal Government. Although most comes from LSC grants, offices receive some funds from sources such as Older Americans Act, Community Services Block Grants, and Title XX moneys. The balance of funds come from State and local governments and private sources.

Administration's Proposed Fiscal Year 1988 Budget

The President's request would eliminate LSC in 1988 with no funding to allow for completion of responsibilities.

The President expects private attorneys and bar associations to provide legal services to the poor, and if States need to supplement these activities, they could do so with Social Services Block Grants. (However, Title XX was cut by 20% in 1981. It was originally authorized at $2.5 billion in 1976 and ten years later it is only $2.7 billion.)

OLDER AMERICANS VOLUNTEER PROGRAMS

The Programs

ACTION, an independent agency established in 1971, administers and coordinates a variety of volunteer programs designed to reduce poverty, help the physically and mentally disabled, and serve local communities in other ways. The Older Americans Volunteer Programs (OAVP), administered by ACTION, are particularly important to the elderly. These three programs, listed below, unite the time and energy of mature, experienced, and skilled volunteers with unmet community and individual needs. Special emphasis is placed on serving the frail and isolated elderly, and young people who are emotionally, mentally or physically disabled. OAVP projects are locally sponsored and administrated. The FY 1987 appropriation for OAVP was $103.8 million.

A. RETIRED SENIOR VOLUNTEER PROGRAM

The Retired Senior Volunteer Program (RSVP) was established in 1971 under the Older Americans Act. RSVP provides volunteer opportunities for persons age 60 and over in areas such as youth counseling, shelter and food projects for the homeless, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. In FY 1988, literacy education for adults will be given special attention. Volunteers receive no hourly stipend, but can be reimbursed for out-of-pocket expenses incurred as a result of volunteer activities. In FY 1987, RSVP was appropriated funding to provide for 383,000 volunteers.

B. FOSTER GRANDPARENTS PROGRAM

The Foster Grandparents Program (FGP) provides part-time volunteer opportunities for low-income persons age 60 and over. Foster Grandparents provide supportive, person-to-person services to children with physical, mental, emotional or social disabilities. Participants are placed with nonprofit sponsoring agencies such as schools, hospitals, day care centers, and institutions for handicapped children. Volunteers serve 20 hours per week and provide care on a one-to-one basis to three or four children.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits,and meals while serving as volunteers. Volunteers must meet income guidelines to qualify for this program and benefits are not taxed. However, those older persons who are not income-eligible may now serve without the stipend, as a result of amendments to the 1986 ACTION reauthorization bill but receive the other benefits. In FY 1987, Congress appropriated funds to FGP to support 23,800 Foster Grandparents.

C. THE SENIOR COMPANION PROGRAM

The Senior Companion Program (SCP) was instituted in 1973. Senior Companions are low-income persons age 60 and over who provide personal assistance and companionship primarily to older adults. These older adults have physical, mental, or emotional impairments which put them at risk of institutionalization or who could not be deinstitutinalized without the aid of the Senior Companion. Volunteers must meet the same income qualifications and receive the same benefits as FGP volunteers. Non-eligible older persons may serve without the stipend, as a result of amendments to the 1986 ACTION reauthorization bill, but receive the other benefits. In FY 1987, SCP was appropriated funds to support 7,000 Senior Companions.

The Administration's Proposed Fiscal Year 1988 Budget

For Older American Volunteer Programs, the President's budget requests budget authority of $103.6 million, the same level as FY 1987. At this level, the President projects the following:

--**RSVP.**--$29.6 million; 392,000 volunteers could be supported at this level, an increase of 9,000 over the number in FY 1987.

--**FGP.**--$56.1 million; 23,800 Foster Grandparents could be supported at this level, a number equal to the FY 1987 level.

--**SCP.**--$18.1 million; 7,000 Senior Companions could be supported at this level, a number equal to the FY 1987 level.

COMMUNITY SERVICES EMPLOYMENT FOR OLDER AMERICANS

THE PROGRAM

Community Services Employment for Older Americans was established by Title V of the Older Americans Act and is administered by the Department of Labor's Employment and Training Administration. This program provides part-time work experience to unemployed, low-income persons age 55 and over through contracts with seven national service organizations and the U.S. Forest Service and through grants to the states. FY 1987 appropriations for this program were $326 million. This will maintain 89,000 participants.

THE PRESIDENT'S PROPOSED BUDGET

The President requests funding of $326 million in FY 1988 for this program, the same level as FY 1987.

JOB TRAINING PARTNERSHIP ACT

THE PROGRAM

The Job Training and Partnership Act (JTPA), a state-administered program, authorizes a wide range of training activities to prepare disadvantaged persons for unsubsidized employment. Three percent (22,587) of the participants in Title II-A of this program during the period July 1, 1985 through June 30, 1986 were 55 years and older. Three percent of the Title II-A JTPA funds of each State's allotment are set aside to be made available for the training and placement of older individuals in employment opportunities with private business concerns. The set aside for the 1987-88 program year is $55.2 million.

The set aside for FY 1988 is $53.5 million, almost $2 million less than FY 1987.

Title III of JTPA authorizes a State-administered dislocated worker program which provides training and related employment assistance. In the program year from July 1, 1985 through June 30, 1986, eight percent (7,648) of those individuals who went through the program were 55 years of age or older. The total fiscal 1987 appropriation for JTPA programs is over $3.66 billion.

It is intended that these programs coordinate with the Older American Community Service Employment Program when necessary.

THE PRESIDENT'S PROPOSED BUDGET

The President's fiscal 1988 budget includes $3.3 billion for programs currently authorized by the JTPA, with the exception ot the Title III dislocated worker program, which he proposes be removed from JTPA and funded as a separate program at $980 million. An additional request for $150 million for Summer Youth Programs has been made. The budget proposes funding the Block Grant Program to states at $1.78 billion for 1988, which is estimated to serve one million participants compared to $1.840 billion provided in 1987. The budget proposes a 1987 rescission of $57 million, decreasing enrollments by approximately 16 thousand participants. Block grants to states provide funds to design and operate those programs of training and other employment assistance to the economically disadvantaged.

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

THE PROGRAM

The Equal Employment Opportunity Commission (EEOC) enforces various laws which prohibit employment discrimination based on factors such as race, religion, or sex. The EEOC enforces the Age Discrimination in Employment Act (ADEA), an anti-discrimination law of particular importance to senior citizens. This act prohibits age-based discrimination against workers age 40 and over. The 1986 amendments to ADEA removed the age 70 cap, which had been in place previously with certain exceptions. In 1986, older Americans filed 14,000 claims involving age discrimination and equal pay with the Commission and increases are expected in the future. Under Title II/ADEA, which covers discrimination against females 40 years and older, 3,589 claims were filed for an overall total of 17,443 claims filed. The EEOC will spend approximatley $137.5 million this year to carry out its many enforcement activities.Total budget expenses are expected to be $169.5 million in FY 1987.

THE PRESIDENT'S PROPOSED BUDGET

The President's budget requests funding the EEOC at $193,457 million. The request would put fiscal 1988 outlays at $190,329 million, including enforcement activities at $155,788 million.

SOCIAL SERVICES BLOCK GRANTS

THE PROGRAM

States receive Social Services Block Grants (SSBG) under Title XX of the Social Security Act, to provide services to low-income persons, including recipients of AFDC, SSI, and Medicaid Program funds. Services include programs designed to: prevent, reduce, or eliminate dependency on Federal assistance; assist low-income persons to achieve or maintain self-sufficiency; prevent neglect and abuse; prevent or reduce inappropriate institutional care; and secure admission or referral to institutional care when other forms of care are not appropriate. Of particular importance to elderly are such SSBG funded services, such as day care, homemaker and chore services and adult protective services. States receive grants based on population size. In fiscal 1987, Congress appropriated $2.7 billion to the program.

State governments spend an estimated 15 percent of SSBG funds on the elderly. This percentage has declined from over 21 percent in 1981. A major reason for this decline has been the lack of increased funding to make up for the 20 percent cut in Title XX in 1981. Title XX, which was first authorized at $2.5 billion in 1976, is now funded at $2.7 billion. When inflation is factored in, funding for its key services are almost half of what it was a decade ago. This has unfortunately resulted in reductions in programs benefiting the elderly because of decisions to fund needed services for other populations, e.g. day care services and homemaker training.

THE PRESIDENT'S PROPOSED BUDGET

The President's request for FY 1988 proposes $2.7 billion at the same level as FY 1987.

COMMUNITY SERVICES BLOCK GRANTS

THE PROGRAMS

Community Services Block Grants (CSBG) are provided to States for funding services and activities designed to reduce poverty and promote community development. Some CSBG funds are used to provide services to senior citizens such as job training and referral for the elderly, home owner counseling, low-income housing construction, transportation, senior centers, energy and weatherization assistance, and food and shelter.

For FY 1987 the President requested elimination of the CSBG program, and asked that it not be given an appropriation. The Administration considered the program duplicative and would use SSBG funds to address the needs now met with CSBG. The request assumed that the SSBG program would fill gaps in services caused by the cancellation, however, did not provide increased funds to SSBG's to cover the additional duties.

THE PRESIDENT'S PROPOSED BUDGET

For FY 1988, the President is not proposing elimination of CSBG, but is requesting $312 million, a $58 million cut in the program funding from the FY 1987 $370 million budget. This would clearly reduce the CSGB services upon which many senior citizens depend, especially those who are low income.

ITEM 2

IMPACT OF THE PRESIDENT'S FISCAL YEAR 1988 BUDGET: SELECTED PROGRAMS BENEFITTING THE ELDERLY

March 13, 1987

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PREFACE

Some judge the President's budget proposal "dead on arrival". The issue is not whether this budget arrived belly up or armed for battle. A budget will emerge from Congress, be it the Administration's or some other, and cuts will be part of that budget.

As we put the President's budget under the microscope and dissect it, we must ask whether it mirrors or mutates our historic commitment to a secure, healthy old age for all Americans. In the past two decades--particularly since the creation of Medicare--we have witnessed great strides in the financial and physical well being of the elderly in this country. But the miracles of Medicare and the securities of our social programs were not pulled from a magician's hat. They were built with the hard earned dollars of the American taxpayer -- and the wisdom of Congress in investing those dollars in programs that benefit us all.

To take pride in our successes is justified, but not as an excuse to fall back in our efforts. We must not turn our back on 20 years of commitment by "nickle and diming" our achievements to death.

As Congress prepares its budget proposals for fiscal year 1988, we must reject proposals that jeopardize the economic well-being of the elderly or the quality of services provided by Federal programs. Unfortunately, too many of the President's proposed cuts in programs such as Medicare and Medicaid would renege on our commitment to the elderly.

This report, prepared by the Committee's minority staff, summarizes the impact of the President's budget on selected programs serving the elderly, and provides information that will guide the preparation of the fiscal year 1988 budget.

JOHN HEINZ
Ranking Member

ESTIMATES OF FY88 OUTLAYS
CURRENT SERVICES AND ADMINISTRATION PROPOSALS
Selected Programs Benefitting the Elderly

		FY88					
		Administration			CBO Estimates		
PROGRAM	FY87	Current Services	Proposal	Savings	Current Services	Proposal	Savings
Medicare	$ 71.6	$ 78.2	$ 73.0	$ 5.2	$ 83.1	$ 78.0	$ 5.1
Medicaid	27.3	28.1	26.8	1.3	30.0	28.2	1.8
NIH	5.5	6.0	5.5	0.5	6.0	5.6	0.4
Soc. Sec.	208.5	219.5	219.4	0.1	221.0	220.8	0.2
SSI	10.9	12.3	12.3	0	12.2	12.2	0
R.R. Ret.	6.5	6.8	6.7	0.1	6.7	6.7	0.0
Civ.Ser.Ret.	25.7	27.6	26.1	1.5	27.2	26.3	0.9
Miltry.Ret.	18.1	18.8	18.8	0	19.1	19.1	0
Vet.Prgrms	26.8	27.5	27.2	0.3	27.4	26.7	0.7
OAA	0.7	n/a	n/a	n/a	0.8	n/a	n/a

I. HEALTH PROGRAMS

OUTLAYS
(in $ billions)

		FY88			
		Administration		CBO Estimates	
PROGRAM	FY87	Current Services	Proposal	Current Services	Proposal
Medicare	$71.6	$78.2	$73.0	$83.1	$78.0
Medicaid	27.3	28.1	26.8	30.0	28.2
NIH	5.5	6.0	5.5	6.0	5.6

MEDICARE

Overview: For FY88, the budget proposes $4.7 billion in program savings and $2.3 billion in revenues through premium increases and expansion of Medicare coverage to state and local employees. Over 5 years, it proposes about $25.9 billion in program savings and $26.9 in revenues. When compared to current law, Medicare will contribute about $50 billion to deficit reduction for FY88-92 through program changes, premium increases and other increases in revenues.

Under current law, Medicare outlays for FY88 would increase 10.8 percent over FY87. Under the Administration's budget, they would increase 4.8 percent, resulting in a 6 percent change from the current services level.

The PRO budget in FY88 is $176 million, an increase from FY87's budget of 170 million.

In 1988, Medicare will serve 30 million aged and 3 million disabled persons.

ADMINISTRATION ESTIMATES
(in $ millions)

OUTLAYS	FY87	Current Services FY88	Proposed FY88	Change From FY87	Change From Cur.Serv.
Total Outlays	$78,159	$86,588	$81,912	$3,747	$-4,687
Offsetting Receipts	-6,545	-8,340	-8,881	-2,336	-541
Net Outlays	71,614	78,248	73,032	+1,411	-5,216

Beneficiary Cuts: Beneficiaries currently pay, on average, more than 15 percent of their incomes on out-of-pocket health care costs. There are several proposed changes in the budget which would increase the out-of-pocket costs of Medicare beneficiaries. Beneficiaries would directly absorb about 4 percent of the cuts in 1988; however, the impact in the outyears is greater as a result of the premium and deductible increases. The proposals are:

- One month delay in eligibility for Medicare
  Savings -- FY88 = $295 million; 5 Years = $1.7 billion

- Increased Part B Premium
  Savings -- FY88 = $571 million; 5 Years = $15.7 billion

  -- The premiums for current enrollees would be set at 25 percent of program costs (current law).

  -- In 1988, the premium would be set at 35 percent of program costs for new Part B enrollees.

  -- Premium would be set at 50 percent for third party payers. This primarily affects the States, which pay the Medicare premium for Medicaid beneficiaries.

  Under this proposal, premiums would increase as follows:

		1988	1989	1990	1991	1992	Total Increase
Present Law		22.80	23.60	24.40	25.30	26.10	
Admin.	25%	22.30	25.80	28.50	31.80	34.40	32%
Proposed	35%	31.20	36.10	39.90	44.50	48.20	85%
Increase	50%	44.60	51.60	57.00	63.60	68.80	164%

  This proposal imposes increased out-of-pocket costs on all beneficiaries, but particularly on those who enter the program after Oct. 1, 1988.

- Index Part B deductible to Medicare Economic Index. This would increase from $75 in 1987 to about $77 in 1988.
  Savings -- FY88 = $24 million; 5 years = $725 million

- Extend Medicare as Secondary Payer for Disabled Beneficiaries who work for medium sized firms with group health insurance (25 to 99 workers).
  Savings -- FY88 = $120 million; 5 years = $810 million
  Note: OBRA of 1986 made Medicare secondary for firms with 100 employees or more. (House conferees accepted large employers only after a long fight.) Employers oppose it as another cost-shift to the private sector.

Provider Cuts: Some of these items were proposed last year, and others call for repeal of provisions that were included in the Omnibus Budget Reconciliation Act of 1986. Unlike last year, the Administration is proposing most of the changes through legislation. Only two provisions would be achieved through regulatory initiatives (PPS for capital; eliminate return on equity for SNFs; outpatient departments). The proposed FY88 savings are distributed as follows:

hospitals = 57 percent;
other providers = 4 percent;
third parties (states and employers) = 18 percent;
physicians = 17 percent.

Note: Savings figures are only provided for FY88.

- Establish PPS for Capital (No savings in FY88). Implement through regulation a 10-year transition for fixed capital and a 2-year transition for moveable capital to PPS, assuming the same payment reduction (7 percent) that was included in OBRA of 1986. Plan is not specific so that it is not clear whether there is grandfathering of old capital.

- Restore discretion of Secretary to Establish Update Factor for PPS Rates ($510 million). OBRA of 1986 removed the Secretary's authority to determine the percentage change in PPS rates for FY88 by setting the rate of increase at market basket minus 2 percent. This would restore the Secretary's authority and assumes that the update would be 1.5 percent (subject to change).

- Changes in Medicare payments for direct medical education. ($310 million). Legislative changes to repeal the COBRA prohibition against further limits on direct medical education costs and to eliminate other education payments including: (1) classroom and other educational program costs; and (2) payments for undergraduate nursing and allied health professional education.

- Reduce Indirect Medical Education Payments ($835 million). Would reduce indirect factor to 4.05 percent.

- Eliminate Periodic Interim Payments for Disproportionate Share hospitals ($1,180 million).

- Modify prompt payment standards ($890 million). The OBRA provision regarding payment of clean claims would be modified to extend the 30 day ceiling to FY88 and beyond.

- Eliminate return on equity for Skilled Nursing Facilities (SNFs) and hospital outpatient departments. ($60 million).

- Place hospital radiologists, anesthesiologists and pathologists (RAPs) under prospective payment for inpatient services. ($10 million). Medicare would pay an average rate for the RAP services associated with a specific procedure.

- Other physician reimbursement reforms. ($190 million). Includes further reductions for cataract surgery (13 percent on top of OBRA's 10 percent cut); limit customary charges of new physicians at 80 percent of the prevailing charge; reductions in other "overpriced physician charges;" limits on prevailing charges for certain medical or surgical services where there is a large disparity between the charges of a specialist and non-specialist.

- Include state and local employees hired after March 31, 1986 under Medicare (revenue increases of $1.6 billion in FY88). Note: This is a big revenue producer and good policy, but House will probably resist again.

- Repeal of specified provisions in the Omnibus Budget Reconciliation Act of 1986 ($323 million):

  -- extension of Medicare coverage to vision care services performed by optometrists.

  -- expansion of Part B coverage to additional occupational therapy services.

  -- expansion of Part B coverage to, and separate payment for, the services of physician assistants who furnish services under the supervision of a physician.

  -- ESRD facility rates and replacement with "appropriate rates based on available data and confirmed by the GAO."

MEDICAID

ADMINISTRATION ESTIMATED OUTLAYS
(in $ millions)

Current Services	Proposed Outlays	Change
FY86 = $24,995	$24,995	--
FY87 = 26,700	26,700	--
FY88 = 28,120	26,864	**-$1,256**
FY89 = 30,870	28,035	**-$2,835**

OVERVIEW

The Administration proposes a $1.3 billion reduction in Medicaid expenditures for FY88 and $2.8 billion in FY89. Thus, expenditures are reduced by 4.5 percent in FY88 and 9.2 percent in FY89. Total reductions for five years (FY88-92) are $16 billion.

The largest portion of the savings ($1 billion of $1.3 billion) is in the form of limits on benefit payments; the remainder are administrative reductions.

Changes Affecting Beneficiaries

Cost Cap: As in the past several budget submissions, the Administration is again proposing a reduction in Medicaid expenditures -- $1.3 billion with an offsetting "contingency fund" of $300 million for states with "unusual cost increases" -- with a cap on future program growth. Future increases in Medicaid will be limited to the Medical Care Component of the Consumer Price Index. Federal payments will continue to match State expenditures, but only up to the State's growth limit.

Revised Spend-Down Provisions: States would be required to impose eligibility restrictions on beneficiaries who transfer assets for less than fair market value if, without the transfer, they would have been ineligible for the program. Would be modeled after SSI program. (Saves $20 million in FY88).

Infant Mortality Initiative: Demonstration project to provide comprehensive case management services to pregnant women. (Cost: $85 million in FY88).

Administrative Changes

Elimination of Special Matching Rates: All administrative matching rates would be equalized at 50 percent to "encourage efficiency." This affects administrative costs for family planning services, information systems, skilled medical personnel, survey and certification activities, contracts with PROs and fraud control. Payments are phased out as costs exceed national median. (Savings: $360 million in FY88).

Other: Reimbursement limits would be imposed on non-emergency care provided in Hospital emergency rooms (saves $80 million in FY88); administration of patient care and facility certification inspection processes in long term care facilities (savings ?)

Analysis

Cost Cap would fundamentally alter the Medicaid program. Placing a cap on the federal match would change the Medicaid program from an entitlement to a "block grant." Some states will be able to absorb the additional costs; most will not and administrative efficiencies can only produce modest additional savings.

Despite a projected growth in eligible beneficiaries of 441,000 (1.8 percent) the proposal would reduce projected expenditures for benefits by $1.3 billion (4.5 percent) in FY88, allowing the program to grow by only $164 million (0.6 percent).

The cost cap has been proposed in the last several budget proposals and has been soundly rejected by Congress each time. There are not good estimates of the number of poor people who might be denied or given inadequate health care if this proposal is enacted. It is generally believed, however, that such a cap would increase the disparities that now exist between states and eliminates the possibility of needed improvements in states' Medicaid programs.

Administrative changes could hinder monitoring efforts by states. The administrative changes are relatively small in comparison to the cost cap, but reductions in the federal match for PRO activities and survey and certification could contribute to a deterioration in the already poor quality of care provided in many nursing homes. Moreover, states may devote more of their own funds to administration (to make up for any loss in federal funds), but this may be to the detriment of services to the needy.

NATIONAL INSTITUTES OF HEALTH

The Administration estimates that its proposed FY88 budget for NIH would increase the agency's total outlays by $80 million over FY87 outlays. Budget authority would actually only increase by $10 million over FY87. This figure includes an increase of $91 million for AIDS research (from $253 million in FY87 to $344 million in FY88). DHHS proposes a recision of $72 million in Research Project Grants and other research activities for FY88 appropriations (from $5.6 billion in FY87 to $5.5 billion in FY88). This will translate into a proposed reduction in new and competing research projects of 700, from 6,400 in FY87 to 5,700 in FY88. The Administration proposes that Congress appropriate full budget authority associated with multi-year research project grant commitments in the year for which the project grant is approved.

NATIONAL INSTITUTE OF AGING

Under the DHHS proposal, total outlays for NIA will be reduced by approximately $1.2 million for FY88 (from $167.2 million in FY87 to $166 million in FY88). This is fairly evenly distributed between research project grants, centers and training. Despite the reduction of $0.5 million in research project grants, the actual number of grants will remain the same (537). The FY88 appropriations request includes $56.9 million for Alzheimer's disease research, the same amount as appropriated for FY87. Funding for training is reduced by $0.3 million.

Note: The figure for FY87 includes $11 million that the Administration would like to "roll over" to FY88. The request of $237.9 million for FY88 includes $81 million in advanced appropriation for FY89-91.

HEALTH PROFESSIONS EDUCATION

The proposal for Health Professions Education is a 54 percent decrease from the FY87 allocation, from $68 million to $31 million. This follows on a 64 percent decrease from FY86 to FY87, from $187 million to $68 million. The proposal for FY88 is $204 million of which DHHS plans to rescind $135 million.

The Administration feels that the supply of physicians is now adequate to meet the country's medical needs and proposes the elimination of grants for training of health professionals, replacing it with market rate loan guarantees. The exceptions to this would be for geriatric training and family medicine training programs whose funding will remain at the current level.

II. INCOME MAINTENANCE PROGRAMS

OUTLAYS
(in $ billions)

		FY88			
		Administration		CBO Estimates	
PROGRAM	FY87	Current Services	Proposal	Current Services	Proposal
Social Security	$208.5	$219.5	$219.4	$221.0	$220.8
SSI	10.9	12.3	12.3	12.2	12.2
Railroad Retirement	6.5	6.8	6.7	6.7	6.7
Civil Service Retirement	25.7	27.6	26.1	27.2	26.3
Military Retirement	18.1	18.8	18.8	19.1	19.1
Veterans Programs	26.8	27.5	27.2	27.4	26.7

SOCIAL SECURITY

BENEFITS

No proposed changes in social security benefits or COLAs. Under current services estimates, outlays for benefits (in billions) will be:

FY86	$196.5
FY87	205.5
FY88	216.9
FY89	230.0
FY90	244.4
FY91	259.1
FY92	273.2

PAYROLL TAXES

Proposals to increase the payroll tax revenues:

1. Require employers to pay taxes on the full amount of cash tips. Currently, employer liability is limited to the portion of tips considered to be wages under the Minimum Wage law. This proposal would raise $0.2 billion in FY88.

2. Extend Social Security coverage to earnings by armed forces reservists on inactive duty, student workers, agricultural workers, children employed by their parents, and spouses employed by the other spouse.

3. Conform the Social Security treatment of group term life insurance to the income tax treatment. Currently, social security does not tax these employer-provided benefits, although to the extent that the face value of the policy is greater than $50,000, the cost of the policy is imputed as income to employees for income tax purposes under a uniform, age-adjusted schedule set by the IRS.

Proposals 2 and 3 would together raise $0.3 billion in FY88.

S.S.I.

No cuts in benefits or COLAs have been proposed. The CBO current services estimate for FY87 outlays is $10.9 billion for the SSI program. In FY88 this figure will grow to $12.2 billion. The significant increase in outlays is not due to an expansion of eligibility or benefits. Because of the way the calendar falls, the October 1988 benefits (which would normally be part of the FY89 budget) will be mailed in September 1988, causing 13 monthly benefit payments to be included in the fiscal year.

RAILROAD RETIREMENT

OUTLAYS
(in $ millions)

	S.S. Equiv.	Pension Equiv.	Suppl. Annuity	Windfll Benefit	Admin.	Total Spending	S.S. Intrchng
ADMIN. EST.							
FY87 Current Services	3,832	2,215	117	380	57	6,601	-2,746
FY88 Current Services	3,957	2,298	116	368	54	6,793	-2,850
FY88 Budget Proposal	3,957	2,298	116	276	54	6,701	-2,850
FY88 Legis. Proposal --	yields $27 in savings					6,674	
CBO EST.							
FY87 Current Services	3,832	2,150	117	380	59	6,538	-2,746
FY88 Current Services	3,974	2,303	116	276	63	6,732	-2,850
FY88 Budget Proposal	3,974	2,303	116	276	54	6,723	-2850
FY88 Legis. Proposal --	yields $32 in savings					6,691	

BENEFITS

The Administration proposes additional outlays of $65 million for FY88. This increase is the result of two factors:

1. The obligation to pay Vested Dual Benefits would be transferred to the Rail Industry Pension Fund. This increases outlays approximately $92 million in FY88.
2. The $92 million increase would be offset somewhat by cancelling the Tier II COLA for 1988. CBO estimates savings from the COLA cancellation of $32 million, OMB estimates savings of $27 million.

(Note: other proposals, basically administrative cutbacks, have some impact on the $65 million figure.)

PAYROLL TAXES

The Administration proposes an increase in the payroll tax rates for Tier II benefits (that part of the retirement system roughly equivalent to a private pension). Currently, employees mandatorily contribute 4.25 percent of their pay, up to $32,700. Employers contribute 14.75 percent of an employee's pay, up to $32,500. Thus, 19 percent of pay is contributed to this fund.

The proposed budget would increase the total of pay contributed to 20.5 percent in 1988 and 22 percent in 1989. There is ambiguity in the budget summary as to whether the additional contributions would come from employers, employees or a combination.

There will be no changes proposed for the Tier I payroll taxes, which are identical to Social Security taxes -- 7.15 percent from both employer and employee up to $43,800.

CIVIL SERVICE RETIREMENT

The Administration proposes lowering the level of COLAs payable under the Civil Service Retirement System (CSRS) to "bring them in line" with the new Federal Employees Retirement System (FERS) which is effective for those Federal workers now under Social Security.

The proposal would lower the COLA to CPI minus 1 percent in years of inflation of more than 3 percent. It would be given at 2 percent in years when CPI is between 2 and 3 percent, and at full inflation if CPI is less than 2 percent.

The proposed budget also calls for the elimination of the retirees ability to withdraw their own contributions in a lump sum at retirement under either CSRS or FERS.

ADMINISTRATION ESTIMATES OF OUTLAYS
(in $ billions)

	Current Services	Proposed	Change
FY86	$24.0	$24.0	--
FY87	26.5	26.5	--
FY88	27.6	26.1	-$1.5
FY89	29.1	27.4	- 1.7

MILITARY RETIREMENT

The administration has not proposed changes or reductions in military retirement benefits or COLAs. Under current services levels, outlays for FY88 will total $19.1 billion.

VETERANS PROGRAMS

MEDICAL CARE

No-cost care will continue to be provided to all service-disabled veterans as well as to former POWs, veterans exposed to certain toxic substances and radiation, veterans of wars prior to World War II, and those receiving VA pensions.

For other veterans who meet certain income guidelines ($20,000 for a single veteran, $25,000 for a veteran with 1 dependent), the Administration "will provide funding" for hospitalization services. This is not a committment to provide care to all of these veterans who need it. (Note: These income guidelines went into effect in July 1986.)

For those with incomes above these guidelines, the VA would still be allowed to provide care non-hospital care "to the extent that resources remain available." In recent years, these resources have been increasingly limited.

COMPENSATION

Veterans compensation benefits are paid to those with service-connected disabilities. In the past, increases in these benefits have not been tied to the CPI, but are appropriated separately by Congress. In some years, the increases are greater than CPI-related COLAs, on the theory that disabled veterans are needier than other groups of beneficiaries. In at least one year, the increase was lower than the CPI.

The Administration proposes tying these benefits to the CPI to make them more predictable and more comparable to other Federal benefit programs.

PENSIONS

No changes are proposed for this program, which provides pension income for veterans without service-connected disabilities.

PENSION BENEFIT GUARANTEE CORPORATION

The PBGC has proposed raising $347 million from the single-employer termination insurance program through legislation to create a "variable rate premium". Currently, all pension plans insured through this program pay $8.50 per participant per year to the PBGC. The PBGC proposes that this premium be raised for pension plans that currently have unfunded pension liabilities in relation to the size of those liabilities. There is no specific proposal yet, however, PBGC will probably propose keeping the $8.50 premium for plans that are funded to meet their termination liabilities plus have some buffer (e.g., termination liabilities plus 10 or 25 percent). Plans funded below this level would pay an additional $6 to $10 per $1,000 of "underfunding". The PBGC proposal may also provide some mechanism for automatically adjusting the premium to meet actual PBGC liabilities in the future.

NET OUTLAYS
(in $ millions)

		FY88			
		Administration		CBO Numbers	
PROGRAM	FY87	Current Services	Proposal	Current Services	Proposal
PBGC	$- 4	$ 171	$-175	$ 161	$-137

III. SOCIAL SERVICES PROGRAMS

OUTLAYS
(in $ billions)

PROGRAM	FY87	FY88			
		Administration		CBO Numbers	
		Current Services	Proposal	Current Services	Proposal
OAA	$ 0.7	$ n/a	$ n/a	$ 0.8	$ n/a
SSBG	2.7	2.7	2.7	2.7	2.7
CSBG	0.4	0.4	0.3	0.4	0.3

OLDER AMERICANS ACT PROGRAMS

For FY87, CBO estimates outlays of $701 million for Older Americans Act programs (exclusive of those administered by the Departments of Agriculture and Labor). Assuming current serivces, these outlays would rise to $773 million in FY88.

The Administration proposes grouping Older Americans Act programs with other social programs (e.g. Head Start, Native Americans, Child Abuse, etc.) under the heading "Social Services Discretionary Programs". They will not be making specific monetary requests on a program-by-program basis, but would cut $34 million from the total requests for these programs. It is unclear how these cuts would be distributed and what the impact would be on aging programs.

Their request for Budget Authority (in $ millions) shows:

	1986	1987	1988	Change
Head Start	$1,040	$1,131	---	
Aging Programs	**671**	**712**	---	
Child Welfare Programs	218	220	---	
Developmental Disabilities	77	84	---	
Child Abuse and Family Violence Programs	27	39	---	
Native American Programs	28	29	---	
Other Social Services	27	29	---	
TOTAL	$2,088	$2,244	$2,210	-$34

The Office of Human Development Services (OHDS) will be submitting a legislative proposal to reauthorize the Older Americans Act which will contain several provisions to target aging programs to low-income, minority, and other "vulnerable" elderly. This would prove a radical departure from the current focus of Older Americans Act programs, which are designed to give access to all elderly.

BLOCK GRANT PROGRAMS

In addition to Older Americans Act funds, the elderly also receive services from other social spending programs such as the Social Services Block Grants and the Community Serivces Block Grants. For FY88, the Administration proposes funding SSBG at current services levels -- $2.7 billion. Spending on CSBG would be reduced from $382 million (the current services level for FY88) to $328 million.

ITEM 3

United States General Accounting Office

GAO

Report to Congressional Requesters

March 1987

SOCIAL SECURITY

Staff Reductions and Service Quality

GAO/HRD-87-66

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-226484

March 10, 1987

The Honorable Lawton Chiles, Chairman
Subcommittee on Labor, Health and
Human Services, and Education
Committee on Appropriations
United States Senate

The Honorable William H. Natcher, Chairman
Subcommittee on Labor, Health and
Human Services, and Education
Committee on Appropriations
House of Representatives

This is the first of three required reports on Social Security Administration (SSA) staff reductions and the quality of service SSA provides to the public. The other two reports will be forwarded to you later this year.

This report (1) discusses changes in traditional SSA service level indicators, such as payment accuracy and claim processing time; (2) analyzes current and past SSA staffing levels; (3) presents the views of SSA employees, managers, and clients on the quality of SSA service; (4) analyzes workloads and processing times for 15 SSA field offices that experienced significant staff reductions; and (5) examines SSA staff reduction actions in implementing its fiscal year 1987 budget.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to other interested congressional committees and members; the Secretary of Health and Human Services; the Director, Office of Management and Budget; the Commissioner, SSA; and other interested parties. We will also make copies available to others upon request.

Edward A. Densmore
for Richard L. Fogel
Assistant Comptroller General

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Abbreviations

AFGE	American Federation of Government Employees
B/D	blind and disabled
DI	Disability Insurance
DRT	data review technician
FTE	full-time equivalent
GAO	General Accounting Office
HHS	Department of Health and Human Services
LAE	Limitation on Administrative Expense
ODO	Office of Disability Operations
OCRO	Office of Central Records Operations
OHA	Office of Hearings and Appeals
RSI	Retirement and Survivors Insurance
SSA	Social Security Administration
SSI	Supplemental Security Income

Chapter 1

Introduction

In January 1985, the Social Security Administration (SSA) announced plans to reduce its staff by 17,000 full-time equivalent (FTE) positions through fiscal year 1990, about a 21-percent reduction in staff. The plan's announcement generated widespread concern that the reduction would impair SSA's ability to provide quality service to its clients. SSA has maintained that service will not be adversely affected, saying that because of planned system and procedural enhancements, fewer staff will be needed.

Despite SSA assurances, in House Report No. 99-289, dated September 26, 1985, the House Committee on Appropriations directed the commissioner of social security to periodically report to the Committee on the quality of SSA service. The report stated:

> "The staffing and facilities issues have brought into focus the concern of this Committee and the Congress as a whole that levels of service be maintained for Social Security beneficiaries and the public in general. In order to better evaluate the effect of changes in Social Security's administrative activities on service, it is essential that the Committee have dependable data on what is happening in the field. This includes regional and national average processing time for processing new or revised claims, posting of earnings or appealing decisions; the accuracy of payments as measured by existing quality control programs; and finally the convenience to the public as measured by commuting and waiting times, etc."

The Committee asked that SSA report quarterly for at least the next 2 fiscal years, and in March 1986, SSA delivered its first report covering the quarter ended December 1985. Three additional reports were issued, the last for the quarter ended September 1986. The reports contained data on SSA's traditional performance indicators, which include payment accuracy, claims processing times for initial claims, and the nature and extent of work backlogs.

In July 1986, the House Appropriations Committee directed the Comptroller General to take over the responsibility for preparing the reports on SSA performance. In its report (99-711), the Committee stated:

> "The issues of staffing levels and field office closings continue to be of great concern to the Congress. Last year the Committee required the Commissioner of Social Security to submit quarterly reports on various measures of service to the public. This information is being used to monitor the effect of staffing and other administrative changes on the public. . . ."

> "While these reports have been very useful to the Committee, there has been substantial concern expressed regarding the objectivity of this self-evaluation. The Committee, therefore, requests that the Comptroller General take over the responsibility for the preparation of these reports in fiscal year 1987. The Committee expects SSA to cooperate fully with the GAO and will expect reports on February 15, June 15, and October 15, 1987. This revised report should be expanded to include staffing levels for the Office of Central Records Operations, the Payment Service Centers, the Office of Disability Operations, the Regional Commissioners (with a breakdown for field offices), and the Office of Hearings and Appeals (with a breakdown for hearing offices). The February 15 report should include historical data on changes in staffing levels over the last 5 years both overall and within the various subdivisions of SSA."

The Senate Appropriations Committee—in Report No. 858, dated August 15, 1986—also expressed concerns about the quality of SSA service and asked GAO to monitor SSA services and provide reports in February, June, and October 1987.

In subsequent discussions with committee staff, it was agreed that we would provide the first report just prior to the fiscal year 1988 appropriations hearings scheduled for mid-March 1987 rather than February 15, 1987. The change provided additional time to incorporate into the report statistics on SSA performance in the first quarter of fiscal year 1987 and its proposed fiscal year 1988 staff reductions.

Objectives, Scope, and Methodology

Our objectives were to (1) assess the quality of SSA service, (2) identify the nature and extent of SSA staff reductions, and (3) determine the effect of staff reductions on service.

To assess the quality of SSA's service, we first compared SSA performance data on key service indicators from fiscal year 1984 through the first quarter of fiscal year 1987. The indicators included payment accuracy, processing times for claims and appeals, workloads pending, and client wait time in field offices. These were selected from among the major performance indicators contained in SSA's four earlier reports to the House Appropriations Committee on the quality of SSA service.

Earnings postings and client commute times to SSA field offices—while discussed in the earlier SSA reports—are not addressed in this report. The biggest problem in recent years with earnings postings—a 39-month postings backlog in the early 1980's—has been eliminated, and earnings are now posted in about 9 months from date of receipt. Commute times were reported as a means of measuring the service impact resulting from office closings. There were no SSA field office closings in the first quarter of fiscal year 1987.

To determine how SSA clients view the quality of the service they receive, we mailed a client satisfaction survey to a nationwide sample of 1,745 clients in November 1986. The survey questionnaire, composed of 44 questions, covered such issues as employee courtesy, waiting times, clarity of program explanations and notices, and overall satisfaction with SSA service. While the sampling strategy was designed to yield an expected sampling error of ± 5 percent at the 95-percent confidence level, the results reported herein are preliminary and are based on a response rate of 70 percent as of January 10, 1987.

The questionnaire was identical to one we sent to clients in November 1984, the results of which were reported in our January 1986 report, Social Security: Quality of Services Generally Rated High by Clients Sampled (GAO/HRD-86-8). Thus, the November 1986 survey not only provides current information on client satisfaction, but also provides an opportunity to analyze whether the public's perception of SSA has changed between 1984 and 1986—a period when the agency absorbed about 4,500 of the projected 17,000 FTE staff reduction.

To obtain the views of SSA employees and mid-level managers about staff reductions, service levels, and other issues, we sent questionnaires to samples of these groups as part of a separate review of SSA's management. Our report on that review, entitled Social Security Administration: Stable Leadership and Better Management Needed to Improve Effectiveness, (GAO/HRD-87-39) will be issued on March 18, 1987. The questionnaire strategy used in this review was designed to yield a sampling error of plus or minus 5 percent at a 95-percent confidence level for each group sampled.

The questionnaires to SSA employees were mailed in March 1986. We mailed 1,094 questionnaires to a nationwide random sample of SSA employees at grade levels GS-5 through GS-13; 905, or 83 percent responded. The sample covered employees, such as claims and service representatives, benefit and claims authorizers, and computer and programming specialists, or about 60 percent of all SSA employees working in Headquarters and field facilities. The questionnaire obtained employees' perspectives about personnel and operational issues such as morale, work assignments, supervision, systems improvements, training and development, and performance appraisals. Also obtained were employees' opinions on the effect of staff reductions and the quality of service to the public.

SSA mid-level managers were mailed a questionnaire in June 1986. The questionnaire was sent to all headquarters deputy associate commissioners, office and division directors, and deputy office and division directors, except for those in SSA's Office of Management, Budget, and Personnel, which is responsible for administrative and support functions. At the field level the questionnaire was also sent to all field deputy regional commissioners, assistant regional commissioners, area managers, deputy program service center directors, program service center process branch managers, regional chief administrative law judges, administrative law judges-in-charge in field hearings offices, and data operations center managers. To obtain the views of SSA's field office managers, questionnaires were also sent to 291 randomly selected district/branch office managers.

In total, we mailed questionnaires to 813 mid-level managers; 645 mid-level managers, or 80 percent of those sampled, responded. The questionnaire covered managers' perspectives on such issues as organizational environment, policy, planning, budgeting, staffing, and performance management, and asked about the adequacy of staffing, the effects of staff reductions, and current and past unit performance.

While we believe the responses to the employee and mid-level manager questionnaires provide useful insights on service and staffing, we also believe caution should be used in interpreting their results. For example, questions about service quality and unit performance are likely to receive positive responses; negative responses could be considered self-incriminating. Further, as a general rule, we believe managers tend to resist reductions of their staff. Likewise, employees will resist reductions if the reductions are perceived as (1) increasing the amount of work they have to do and/or (2) threatening their job security.

To study the potential effect of staff reductions on individual field offices, we visited 15 offices that experienced large staff cuts since fiscal year 1983. We postulated that if staff loss has adversely affected service, the adverse effects should be manifest to a greater and more visible extent in offices that have had larger proportionate loss of staff.

Our purpose in visiting these offices was to determine if there was any substance to the allegation that staff reductions were having a significant adverse effect on service. Our sample size and study methodology precluded us from making any inferences about what has happened or might happen nationally but enabled us to determine whether there was an indication of significant service deterioration in the offices visited.

We selected the 15 field offices from 3 of the 10 SSA regions and from 10 states to obtain some geographical diversity. The offices were selected primarily on the basis of the number and percentage of staff lost. On average, the 15 offices we visited lost about 25 percent of their staff during the fiscal year 1983-1986 period.[1] In comparison, staffing declined 3.3 percent in the same period for all offices nationally and 11.9 percent for only those offices that lost staff. Secondary considerations in selecting offices were office size and location. Most SSA offices have fewer than 50 staff and our selections generally followed the same distribution. Concerning location, we attempted to cover several different states.

The field offices we visited are listed in table 1.1.

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[1] Staff loss for each year was computed on the basis of the average end-of-month staffing levels reported by the field offices.

Table 1.1: Location, Size, and Staff Loss for the 15 Offices Visited

	Number of staff, September 30, 1983	Staff loss—October 1, 1983, to September 30, 1986	
		Number	Percent
SSA Region 2—New York:			
New Rochelle, NY	32	8	25
Jersey City, NJ	105	22	21
New York City, (Brooklyn)—Bedford	32	11	34
New York City, (Manhattan)—Downtown	102	36	35
Schenectady, NY	49	10	20
SSA Region 3—Philadelphia:			
Wilmington, DE	71	17	24
Philadelphia, PA (Kensington and Allegheny Aves.)	28	4	14
Baltimore, MD (West)	22	7	32
Altoona, PA	30	6	20
Martinsburg, WV	17	3	18
SSA Region 5—Chicago:			
Galesburg, IL	24	6	25
Peoria, IL	59	14	24
Detroit, MI (Conner Ave.)	30	5	17
Euclid, OH	19	5	26
indianapolis (West), IN	27	10	37
Total	**647**	**164**	**25**

At each of the 15 offices, we obtained staff opinions on selected issues, including

- the adequacy of current staffing,
- the current level of service provided to the public, and
- the impact of future staff reductions.

In total, we interviewed 89 employees, including 15 office managers, 12 representatives of the American Federation of Government Employees (AFGE) (3 offices did not have a union representative), and 50 claims representatives and service representatives. The managers were interviewed for their overall perspective on office operations and the AFGE representatives because the union has been vocal in opposition to staff reductions at SSA. Finally, claims representatives and service representatives were interviewed because they have the most face to face contact with the public at SSA field offices.

We examined available SSA performance data for those offices. Specifically, for fiscal years 1983-86, we analyzed processing times for initial claims and workload data for the nine most labor intensive workloads for which receipts, clearances, and pendings are reported. These workloads include initial claims for the Retirement and Survivors Insurance (RSI), Disability Insurance (DI), and Supplemental Security Income (SSI) programs, and SSI redeterminations. In fiscal year 1986, these nine workloads accounted for about 70 percent of all field office resources.

To examine staffing changes in field offices nationwide, we obtained office level staffing data for SSA's approximately 1,300 field offices, and determined the number of offices in which staff increased, decreased, or remained the same for the fiscal year 1983-86 period. For offices that lost staff, we determined the percentage and number of staff lost and stratified the results. Finally, we determined the extent to which the various field office staff positions (such as clericals and claims representatives) have been affected by staff cuts.

Our review was made during 1986 through February 1987 and, except as stated below, was conducted in accordance with generally accepted government auditing standards. Because of time constraints, however, we were unable to validate SSA's performance data. For some of the data, however, we determined what controls SSA has and/or what validations it makes to ensure the data's integrity. We also questioned SSA staff to obtain their views on the data's integrity.

Chapter 2

Traditional Performance Indicators Generally Show Stable Service Levels

Traditional SSA performance indicators—payment and process accuracy, claims and appeals processing times, and pending workloads—generally show stability since fiscal year 1984, the year before the agency started implementing its staff reduction initiative. Field office interview wait time data, which SSA began collecting in 1986, show that client wait time has declined each quarter. We believe, however, that reported wait time is understated because not all field office wait time is included in SSA's data and, in some cases, offices take special steps to minimize waiting times when they are measured. This chapter discusses these performance indicators and compares them from fiscal year 1984 through the first quarter of 1987, where data were available as of March 1, 1987.

Accuracy Rates Remain Stable

Payment Accuracy

SSA performance data show that since 1984, payment accuracy rates—the percentage of benefit dollars paid accurately—have generally remained stable for the RSI (which includes disability claims) and SSI programs. Table 2.1 shows the payment accuracy rates for these programs for fiscal years 1984-86. As of March 1, 1987, SSA had not developed RSI and SSI payment accuracy rates for the first quarter of fiscal year 1987 or for the SSI program for fiscal year 1986.

Table 2.1: RSI and SSI Payment Accuracy Rates

Figures in percents

	Fiscal Year			First quarter
Program	1984	1985	1986	1987
RSI	99.5	99.5	99.6	•
SSI	96.7	96.7	•	•

Process Accuracy

SSA performance statistics show that since fiscal year 1984, SSI process accuracy—the percentage of claims processed that were free of payment error—has remained stable. The rates by fiscal year for the 1984-86 period were 97.6, 97.6, and 97.9, respectively. SSA compiles RSI process accuracy rates quarterly, not annually. Table 2.2 shows the quarterly accuracy rates for the RSI and SSI programs for the most recent 5 quarters. As of March 1, 1987, SSA had not developed SSI data for the December 1986 quarter.

Table 2.2: RSI and SSI Process Accuracy Rates

Figures in percents

	Quarter				
	December 1985	March 1986	June 1986	September 1986	December 1986
RSI	96.9	96.6	97.6	97.3	96.6
SSI	98.1	97.8	97.8	98.2	•

According to SSA, the lower RSI process accuracy rates for December and March reflect normal seasonal variations. The SSI rates generally were stable during the period.

Disability process accuracy rates reflect the percentage of disability claims in which medical eligibility for benefits has been correctly determined. Medical determinations of disability claimants' impairments are made for SSA by the states. Table 2.3 shows disability process accuracy rates for both initial claims and reconsiderations where medical eligibility was the entitlement issue. Data for reconsiderations for the first quarter of fiscal year 1987 were not available as of March 1, 1987.

Table 2.3: Disability Process Accuracy Rates for Initial Claims and Reconsiderations

Figures in percents

Fiscal year	Initial claims	Reconsiderations
1984	94.9	94.2
1985	96.3	95.4
1986	96.6	95.5
1987[a]	92.8	•

[a] First quarter

As table 2.3 shows, the accuracy of initial disability claims processed dropped sharply in the first quarter of fiscal year 1987. SSA officials said this is due to the inclusion of mental impairment claims in the overall statistics. These claims had been excluded from overall statistical reports during much of 1986 because of extensive changes in the medical evidence requirements for these claims. When major programmatic changes occur, SSA temporarily excludes affected claims. SSA officials said DI initial claims accuracy should improve as the states gain further experience in adjudicating claims under the new rules. With respect to reconsiderations, the table shows that process accuracy has increased since fiscal year 1984.

Processing Time Performance Varies

Initial Claims

Table 2.4 shows the mean processing times for SSA's initial claims workloads from fiscal year 1984 through the first quarter of fiscal year 1987. Overall, the table shows that processing times have increased for two workloads (DI and SSI-blind and disabled [B/D] claims) and decreased for two (RSI and SSI-aged).

Table 2.4: Mean Processing Times for Initial Claims

Processing times in days[a]

	Fiscal year					
Claim type	1984	1985	1986	First quarter 1987	Days change 1984-87	Percent change 1984-87
RSI[b]	24	22	21	20	−4	−17
Disability	70	70	81	79	+9	+13
SSI-Aged	15	12	10	11	−4	−27
SSI-B/D	74	65	78	80	+6	+ 8

[a] Days rounded to the nearest whole day

[b] Includes health insurance claims

The processing times for DI and SSI-B/D claims include the processing times of state disability agencies. SSA attributes the increase in the processing times for those claims primarily to implementation of the 1984 disability reform legislation, which required more extensive development of mental impairment cases. The general decrease in processing times for RSI and SSI-aged workloads is attributed to increased automation of the claims workload and the establishment of an accelerated claims system for processing less complex claims. Included as appendix I are national processing times for initial claims for the last 5 quarters—December 1985 through December 1986.

On a regional basis, processing times for the initial claims workload vary significantly. For example, during the December 1986 quarter, the Boston Region's mean processing time for an RSI claim was 23 days, while the Philadelphia Region's was 15 days. SSA explained the reasons for such regional variations in its first report on the quality of service:

> "Variations among regions in the processing of workloads have always existed and are the result of a variety of factors, including client characteristics, socioeconomic conditions, the relative performance of Disability State Agencies, geographic area

served, etc. In some instances, variations can be caused by the law. An SSI claim, for example, is a much more difficult work unit in States with supplemental benefits and complex living arrangement situations than in those States which do not include those legal conditions."

Regional mean claims processing times for the December 1985 and December 1986 quarters are presented in appendix II.

Appeals

Reconsiderations—the first level of appeal—are made in SSA field offices and by state disability agencies for DI claims. Since 1984, their mean processing time increased 10 days. Hearings—the second level of appeal—are performed in Office of Hearings and Appeals (OHA) field offices, and since 1984 their mean processing time decreased 6 days. The mean processing time for appeals for fiscal years 1984 through the first quarter of fiscal year 1987 are shown in table 2.5.

Table 2.5: Mean Processing Times for Appeals of SSA Decisions[a]

Figures in days

	1984	1985	1986	First quarter 1987	Days change 1984-87	Percent change 1984-87
Reconsiderations	51	53	65	61	+10	+20
Hearings	185	167	172	179	−6	−3.2

[a]Does not include times for reconsiderations of SSI decisions. SSA currently does not track SSI reconsideration time

According to SSA, the increase in reconsideration times in fiscal year 1986 resulted from the 1984 disability reform legislation's requirements for more extensive development of medical evidence, particularly for mental impairment cases.

Like processing times for initial claims, processing times for appeals also vary by SSA region. Appendix III contains the regional processing times for reconsiderations and hearings for the last 5 quarters—December 1985 through December 1986.

Pending Workloads Show Overall Decline

On an overall basis, SSA's major pending workloads in fiscal year 1986 were down substantially from the levels at the end of fiscal year 1984. Table 2.6 shows the changes for those workloads.

Table 2.6: Pendings for SSA's Major Workloads

Workloads in thousands[a]

	Fiscal year				Percent change	
	1984	1985	1986	First quarter 1987	(84-86)	(86-87)
Field offices:						
RSI claims[b]	151	155	116	108	−23	−7
DI claims	260	233	277	233	+7	−16
SSI-aged claims	13	6	5	3	−62	−40
SSI-B/D claims	169	218	247	218	+46	−12
RSI and SSI overpayments[b]	122	86	106	101	−13	−5
Program service centers:						
RSI claims[b]	92	86	59	53	−36	−10
Overpayments	55	31	16	15	−71	−6
Office of Disability Operations:						
DI claims	49	36	19	18	−61	−5
Office of Central Records Operations:						
Certified wage records for RSI and DI claims	86	58	68	47	−21	−31
Office of Hearings and Appeals:						
Hearings	108	107	117	133	+8	+14

[a] Rounded to nearest thousand.

[b] Includes health insurance claims.

The table shows that pendings for three workloads (DI initial claims, SSI B/D initial claims, and OHA requests for hearings) increased from fiscal year 1984 to fiscal year 1986, while pendings for all other workloads declined. SSA officials attributed the increase in DI and SSI B/D initial claims pending to the effect of the 1984 disability reform amendments, and attributed the increase in OHA hearings pending to a sizable increase in the number of requests for hearings. For example, in fiscal year 1986, hearings receipts in the last quarter increased nearly 50 percent over the number received in the first quarter.

Wait Times Understated

According to SSA, the average time SSA clients wait to be interviewed in field offices has declined steadily since the March 1986 quarter—the first quarter for which SSA collected wait time data nationally. Table 2.7 shows client wait times for the past 4 quarters as measured by SSA.

Table 2.7: SSA Field Office Client Wait Times

	Quarter ending			
	March 1986	**June 1986**	**September 1986**	**December 1986**
Number of visitors sampled	64,793	75,358	69,633	63,684
Average wait time (in minutes)	12.3	10.3	8.9	7.2
Percent of visitors who waited:				
0-5 minutes	53	57	60	62
6-15 minutes	22	22	21	20
16-30 minutes	12	11	11	11
31-45 minutes	6	5	4	3
46-60 minutes	3	2	2	3
Over 60 minutes	4	3	2	1

These data, however, do not completely reflect the length of time individuals spend in field offices waiting for service. SSA's sampling methodology does not measure all the wait time experienced by the public, and some SSA field offices change normal operating practices to reduce wait time during the sampling period.

SSA wait times reported do not include time individuals wait to see a receptionist; instead, they measure only the time from the point a client sees a receptionist to the point that the client sees an SSA interviewer. To learn how long individuals spent waiting to see a receptionist, SSA conducted a special study at 75 offices for 2 weeks in August 1986. The study showed that 41 percent of the visitors had no wait before seeing a receptionist. The 59 percent that did not have direct access to a receptionist, however, waited an average of 8.8 minutes.

Another aspect of wait time not measured by SSA is the time individuals spend waiting in "speed lines," which is a technique that directs individuals whose visit can be handled quickly to designated locations or stations. While this can be a good technique for reducing wait times, four American Federation of Government Employees (AFGE) representatives said speed lines are being used too much, to the point that some speed lines now have long wait times. SSA has instructed field offices—for wait time study purposes—to assume that individuals in speed lines have zero wait times. Consequently, some amount of wait time may not be captured as part of SSA's data.

Finally, interview wait times measured and reported to SSA's central office by the field offices in some cases are not representative of actual wait times because normal practices are not followed during the sampling period. For example, individuals in 6 of the 15 field offices we visited (see chapter 4) said that during the wait time sampling period—a predetermined 30-minute period per week in each field office—offices change their procedures to reduce wait time. Typically, more claims representatives are assigned to conduct interviews of individuals who enter the office during that 30-minute period, and more service representatives are present in office reception areas. The changes have the effect of reducing interview wait time.

The employees' comments in these six offices were reiterated in a written statement by a claims representative. The statement was provided to us by a representative of AFGE, and stated in part:

> "This placid scenario [normal receptioning procedures] changes, however, when the waiting time study sample period comes. Management gets extremely agitated about the people waiting and they round up all available interviewers to take care of the people, whether it is crowded or not. If there are two RSI interviews waiting and both the primary and secondary interviewers are interviewing, they will have another CR [claims representative] interview. This does not occur outside of the sample period. They watch over the interviewing area like hawks for the entire sample time. This is especially true if the sample time occurs during an extremely busy time."

In discussing our observations on waiting time data, SSA officials acknowledged that their study methodology does not capture all wait time at SSA field offices. They said, however, that generally the data collected is adequate to monitor this aspect of SSA service. Concerning the wait time that is not measured, the officials said—because of the cost to capture all wait time—they prefer to monitor these wait times on an ad hoc basis, such as the study which examined the time clients spent waiting to see the receptionist. Concerning the change of office procedures during the wait time study period, SSA officials said they will emphasize to field offices that they report data representative of normal practices.

Other Performance Data Not Collected

We issued in 1986 two reports which addressed the need for SSA to expand its collection of performance data.

The first report, issued in January 1986, (see p. 12) pointed out that SSA does not routinely assess client satisfaction with its service and recommended that SSA conduct periodic client surveys. SSA agreed with GAO's recommendation and developed a plan for doing so. The plan was approved by the Department of Health and Human Services (HHS) on January 29, 1987, and calls for conducting client surveys under a contract arrangement. According to SSA, data on the first survey should be available in the summer of 1988.

The other report—entitled Social Security: Improved Telephone Accessability Would Better Serve the Public (GAO/HRD-86-85)—was issued in August 1986. The report was based on a nationwide test of the public's access to SSA via telephone (e.g. how often did a caller get a busy signal and, if put on hold, how long was the wait) and showed that access to SSA by phone varied greatly across the country.

Because SSA had little information on the accessibility of its phone service, we recommended that SSA periodically measure and evaluate service provided by telephone answering facilities. In a letter to GAO dated January 13, 1987, HHS agreed with GAO's recommendations and said that responsibilities to implement the above recommendation would be assigned to the appropriate SSA components in the near future.

Reliability of SSA Performance Data

Because of the importance of SSA performance data in monitoring the quality of SSA service, we examined the integrity of certain data. The extent of our examination and our observations are discussed below.

Payment and Process Accuracy

We did not validate the SSA payment and process accuracy data contained in this report. Currently, however, we have underway an assessment of the validity of the payment accuracy rates for the RSI program. A report on our assessment is expected in mid-1987.

Processing Times

Claims processing times are derived from SSA automated systems which track for each claim the time from date of application to the date of allowance or denial decisions. Under certain circumstances, SSA procedures allow claims to be removed from the systems prior to date of allowance or denial. For example, if an incorrect account number were established, field office employees can delete the claim in question from the system. This in turn can have the effect of reducing overall field office processing time, particularly when old claims are deleted.

A common allegation is that—to reduce processing time—field office personnel are inappropriately deleting or removing claims from the automated tracking systems. In pursuing this allegation, we inquired into SSA controls over the use of deletions and found that SSA tracks the use of all deletions by all field offices. Consequently, for each field office, SSA has the capability to determine if the use of such deletions are increasing or are excessive in comparison with other offices.

In examining monthly national data on the use of deletions from July 1985 to January 1987, we found that use of deletions was infrequent (for example, about 1.3 percent of all RSI and DI claims) and did not vary significantly from month to month. We did not examine the use of such deletions by individual offices or the extent that SSA field office management used the deletion data to monitor field office performance.

Concerning processing times for hearings, we inquired into what steps OHA takes to assure that its processing time data are accurate. We found that OHA central office staff periodically visit each of its 134 field offices to compare reported processing times with source documents in field office files. OHA officials said that—on the basis of these reviews—the data reported are reliable, particularly when aggregated at the national level.

Waiting Time in SSA Field Offices

The inadequacies of SSA's wait-time data were discussed starting on page 22.

Chapter 3

Questionnaire Respondents Generally View Service as Good but Are Concerned About Staff Reductions

SSA clients, employees, and mid-level managers generally consider SSA's performance or service to be good, and as good as or better than it was a few years ago. Most employees and mid-level managers, however, expressed the view that staff reductions had adversely affected their units.

About 80 percent of SSA clients rated SSA's service as good to very good, according to the preliminary results of a survey questionnaire we mailed in November 1986. These findings are similar to the results of the same survey we conducted 2 years earlier. Similarly, about 92 percent of SSA employees rating SSA service—in a March 1986 GAO survey—said it was good to very good. When asked to compare service then with that of 3 years earlier, 88 percent of the employees that made the comparison said service then was the same or better. Finally, according to a GAO survey of SSA's mid-level managers in June 1986, 88 percent said the performance of their units had improved or remained stable over the last 2 years.

Concerning staffing, 64 percent of SSA's mid-level managers said their units were understaffed. In units that had lost staff, 56 percent of the employees and 71 percent of the managers said the reductions have had an adverse effect on their units' ability to produce quality work.

Client Satisfaction Remains High

Table 3.1 is a comparison between 1984 and 1986 of SSA's clients' responses to some of the key questions about service. As can be seen, generally there is little difference between the 1984 and 1986 responses, but in all cases, client satisfaction or service has improved since 1984.

Table 3.1: Preliminary Results of Client Survey Comparison[a]

Figures in percents[b]

	1984	1986	Increase (decrease)
Quality of service by SSA:			
Overall			
Good to very good	78	80	2
Fair	14	14	0
Poor to very poor	7	6	(1)
Compared to other government agencies:			
Somewhat to much better	51	55	4
About as good	43	41	(2)
Somewhat to much worse	7	5	(2)
Mail from SSA:			
Understandability of mail:			
Generally to very easy	67	78	11[c]
Neither easy nor difficult	15	11	(4)
Generally to very difficult	18	11	(7)[c]
Visits to SSA offices:			
Time spent waiting for service:			
Less than 5 minutes	6	8	2
5 to less than 15 minutes	28	30	2
15 to less than 30 minutes	33	32	(1)
30 minutes or more	33	30	(3)
Courtesy of employees:			
Generally to very courteous	89	91	2
Neither courteous nor discourteous	7	7	0
Generally to very discourteous	4	2	(2)[c]
Explanation of programs and rules:			
Clearly	72	76	4
Somewhat clearly	22	21	(1)
Unclearly	6	4	(2)[c]
How SSA has handled your business so far:			
Good to very good job	73	76	3[c]
Fair job	15	14	(1)
Poor to very poor job	12	10	(2)
Phone calls to SSA:			
Number of attempts to reach SSA:			
Got through on first try	47	52	5[c]
2 times	28	26	(2)
3 times	11	11	0
More than 3 times	14	11	(3)

Phone calls to SSA:	1984	1986	Increase (decrease)
Courtesy of employees:			
Generally to very courteous	89	90	1*
Neither courteous nor discourteous	8	8	0
Generally to very discourteous	3	2	(1)
Explanation of program and rules:			
Clearly	70	72	2
Somewhat clearly	23	24	1
Unclearly	7	4	(3)*
How SSA has handled your business so far:			
Good to very good job	75	78	3*
Fair job	15	14	(1)
Poor to very poor job	10	9	(1)

[a] Percents may not add to 100 because of rounding.

*Indicates a statistically significant difference.

While service generally has improved and client satisfaction remains high, the data also show that one in three people wait 30 minutes or more for service in field offices and about half don't get through to SSA on their first telephone call.

Employees Say Service Better Than in Past

Of the employees who responded to our March 1986 questionnaire, 92 percent rated their unit's service as good to very good; 52 percent said their unit's service then was somewhat or much better than it was 3 years earlier while 35 percent said their unit's service had remained about the same.

Of the 905 employees who responded to the questionnaire, 372 provided 558 narrative examples as to why or what about their unit's work or service to the public was better than 3 years ago. The examples most frequently covered the following issues:

- Faster processing time (102).
- Greater accuracy (83).
- More experienced personnel (77).
- Additional or increased use of automation (49).
- Improved staff training (34).
- More quality control (26).

A sampling of employees' narrative comments follows:

- "Improvements to software that significantly reduced manual operations by district office personnel."
- "Our staff is more experienced now."
- "Our processing time for initial claims has been reduced since 3 years ago."
- "State of the art in software and hardware is vastly improved over 3 years ago. This allows us better methods, response time, and quality of product."
- "We have been given some 'quiet time' when we can do our desk work undisturbed. This has made our work-flow much better."
- "Low turnover of skilled technicians, hence improvement due to more experience."

In contrast, 88 employees provided 118 narrative examples as to why or what about their units' work or service to the public was worse than 3 years ago. The examples most frequently covered the following issues:

- Insufficient Staff Resources (21).
- Hurried Interviews (16).
- Increased Workload (14).
- Increased Payment Errors (12).
- Emphasis on Quantity over Quality (11).

A sampling of employees' narrative comments follows:

- "Branch office converted to a Resident Station, combined with loss of personnel, results in inadequate number of people to properly perform duties, requires work not in job description."
- "Reduced staffing has increased waiting times for interviews. Clerical staff is definitely overburdened, unable to file cases . . ."
- "We are forced to handle large volumes of work with less people and we hurry thru interviews in order to clear as many claims as possible."

Staff Reductions Are Said to Have an Adverse Impact

About 55 percent of the employees said their units lost staff in fiscal year 1985 and about 56 percent of these said that the loss had a somewhat (40 percent) or significant (16 percent) negative effect on the ability of their units to produce quality work. A total of 234 employees provided 418 examples of the adverse effect. The most frequent examples were:

- Larger workloads to process for remaining staff (113).
- Lower morale, and more stress, apathy, and frustration (84).

- Backlogs and untimely processing of workloads (61).
- Less accuracy in their work (36).
- Tasks inappropriate for grade level (34).

A sampling of narrative comments from employees follows:

- "Results in more work per person. An increase in 'other duties as assigned'—We are a small small office and we all wear several 'hats'."
- "Backlog."
- "We still had the same amount of work but less people to complete the work . . . The work was not processed timely and the service to the public was not at its best."
- "In conclusion, I have no major problems with my job or work environment except for having to combat the ever-declining morale which exists in the agency as a whole."

Employee Morale Is Low

Concerning employee morale, 53 percent of all employee respondents characterized their units' morale as generally to very low; 19 percent said it was generally to very high.

We asked those employees whose units had low or very low morale to check from a listing of possible reasons why their unit's morale was low. Table 3.2 shows reasons given for low morale.

Table 3.2: Reasons Cited by Employees for Their Poor Morale

Figures in percents

Reason	Frequency cited
Poor promotion potential	63
Too much emphasis on measures such as timeliness, productivity, etc	56
Not enough emphasis on employee development	54
Uneven workload distribution	47
Poor supervision in unit	35
Expectation of a reduction-in-force	35
Poor management in unit	32
Other reasons than those listed	32
Lack of stable leadership in SSA	30
Uncertainty as to future of job	26
Necessary training not available	22
Uncertainty as to future of unit	20
Increasing technological change	17

Mid-Level Managers See Performance Stable or Improving but Are Concerned About Future Staff Reductions

Most managers classified the performance of their units as "improving" (46 percent) or "stable" (42 percent) over the last 2 years. Only 12 percent said their units' performance was declining. The two factors which mid-level managers cited as greatly affecting declining performance were changes in staff levels and in staff morale.

Staff Cuts Seen as Affecting Operations Adversely

About 66 percent of the mid-level managers indicated that their unit lost staff in fiscal year 1985. Of these, 71 percent believed the staff loss had a somewhat (55 percent) or significant (16 percent) negative effect on their units' operation. In explaining the effect, 277 mid-level managers furnished 373 examples, the most frequently mentioned being:

- Decreased quality and less work processed (101).
- Added work for remaining employees (67).
- Increased client waiting time for service (48).
- Loss of best or key employees (38).
- Lower morale and more stress and frustration (35).
- Shortages of support or clerical staff (28).

A sampling of mid-level managers' comments follows:

- "Heavy loss of highly trained personnel has affected the quantity of work, the quality of work and significant negative effect on morale/frustration levels."
- "We are reaching the point where instead of doing more with less, we are doing less with less."
- "Today we are doing much of our work using temporaries, college work study students, summer aides, stay-in-schoolers. The constant training of these employees due to turnover impacts heavily on management time. We are holding the line with their help. If they leave—problems."
- "Less staff—more work. Clerical losses caused other positions to absorb clerical tasks. Everything suffers."
- "The ratio of marginal performers to high quality performers increased."
- "The 'friendly courteous service' is demanded but not measured, thus no staff is provided for taking the time needed to make the public feel 'at home'."

In contrast, 73 mid-level managers who experienced staff cuts perceived positive effects from the cuts. For example, one manager stated: "I was probably overstaffed in 1984. I have cut out most of the fat and its had a very positive effect. Everyone buckles down and does what has to be done."

Regarding the prospect of future staff reductions, about 95 percent of the 645 responding mid-level managers believed that additional cuts in fiscal year 1986 equal to the cuts in fiscal year 1985 would have a somewhat or much worse effect on the unit's ability to produce quality work. The staff cuts for 1986 and other years are discussed in chapter 5.

Most Managers Say They Are Understaffed

Addressing the then-current staffing levels in June 1986, about two-thirds of managers surveyed said their units had less (53 percent) or much less (11 percent) staff than needed, and about one-third said their staffing equaled their staff needs. To learn why most managers believed their units were understaffed, we interviewed 10 district or branch managers (selected at random) who held this view. Four managers told us that their staffing was below authorized levels and that they already filled the positions or that they were in the process of obtaining additional staff. Other managers believed that their understaffing was detrimental to the service they provided (e.g., poor phone service, long wait times, increased backlogs). In their opinion, additional staff would enable adequate service to be provided in these areas.

While some offices may be below authorized levels, that does not necessarily mean that they are understaffed in relation to the amount of work the office should be expected to handle efficiently. In a May 20, 1986 letter to SSA, we provided information showing wide variations in efficiency among field offices caused in part by staffing and workload imbalances among similar offices.

In our report Social Security: Stable Leadership and Better Management Needed to Improve Effectiveness (GAO/HRD-87-39) to be issued on March 18, 1987, we stated that SSA needs to improve its method for computing field office staff needs. SSA's method of authorizing and allocating staff, which is based on an office's historical performance, tends to perpetuate workload and staff imbalances. To reliably determine staff needs, SSA needs to know the amount of time it should take field offices to complete work, rather than relying on how long it took the offices to complete work in the past, and then apply such time to the actuarially and statistically projected workloads.

Chapter 4

A Case Study of 15 Field Offices With Significant Staff Reductions

In 15 field offices we visited that had experienced significant staff reductions since the beginning of fiscal year 1984, most managers and about half of the employees and AFGE representatives we interviewed said that service quality remained good. Management and employees differed concerning the adequacy of current staffing levels, but there was general agreement that additional future reductions in the offices would adversely effect service.

Our analysis of claims processing times and pending workload data for the 1984-86 period indicates a significant deterioration in service for one area—the processing times for SSI-B/D claims. The time to process these claims increased 23 days—from 74 days in 1984 to 97 days in 1986. In comparison, the processing time for these claims nationally increased only 4 days. The principal reason for the larger increase in processing time at the 15 offices is the relatively high processing times of the New York and New Jersey state disability agencies which make the medical determinations for 5 of the 15 offices we visited.

Views of Office Staff on Staff Levels and Service

Views on Adequacy of Current Staffing

Management and employee views on the adequacy of current staffing contrasted significantly. For example,

- 9 of 15 managers said existing staff was adequate to do the job, while
- 43 of the 50 claims and service representatives with whom we spoke and 7 of 12 AFGE representatives said that existing staff was less than adequate.

Managers cited such factors as declining workloads, systems improvements, and more experienced staff as reasons why they considered current staffing as adequate. Several managers expressed the view that their offices were previously overstaffed. One manager said:

- "Our office has kept key people and gotten rid of the dead wood. That is how we have been able to deal with staff cuts and still process the workload. The people who remain are working harder and as a team."

Claims and service representatives and AFGE representatives interviewed generally said they believed that existing staff was being overworked and backlogs were getting larger because current staffing was inadequate. Some specific comments follow:

- "The clericals—claims development clerks—are GS-4s who are so short staffed, they are being worked to death."
- ". . . staffing shortages are so acute that Claims Representatives have to take turns processing social security card applications . . ."
- "Twenty percent of my time is spent doing work formerly done by clericals. We work like hell and can't keep up this pace."

Positions most frequently mentioned as understaffed were clericals, claims representatives, and service representatives. A manager stated that clericals are important in keeping the voluminous claims paperwork flowing. He said the position experiences frequent turnover and it is difficult to find replacements. Several personnel commented that clerical shortages require higher graded personnel to perform the clerical duties, which represents an inefficient use of resources.

Views on Quality of Service

Most managers interviewed in the 15 offices said that SSA provides good service to the public which is about the same or better than the service provided 3 years ago. Employees and AFGE representatives were generally split equally on the quality of current and past service. For example:

- Of the 15 managers, 12 said that SSA's current service was good, and 13 said it was about the same or better than 3 years ago.
- 26 of the 50 claims and service representatives and 5 of the 12 AFGE representatives said that service was good, and 28 claims and service representatives and 6 union representatives said it was about the same or better than 3 years ago.

Pertinent comments from a manager and two employees were:

- "Service quality has improved since 1983 because of the more experienced staff."
- "Would rate service as extremely high. Processing times are good, waiting times aren't bad, and courtesy is OK."
- "A special effort is made by the employees to be courteous and thorough..."

Views on Impact of Future Reductions

While most managers and about half of the employees and AFGE representatives said they believed current service was good, overall there was general agreement that future staff reductions in their units would adversely affect service to the public. Frequently cited service effects of additional reductions were that backlogs would get larger, processing times would increase, and interview waiting times would get longer. Regarding employee morale, many personnel interviewed said that already low morale would go lower if future reductions were imposed.

Pertinent comments were:

- "We're struggling right now. It's not easy. With reduced staff levels in the future, the office will only be able to handle the essentials."
- "Future staff loss could have a domino effect on this office's operations . . . the effects will possibly include increases in processing times and pending workloads and failure to process post-entitlement actions in a timely manner."

Service Deteriorated in One Aspect

Using two key service indicators—how long it takes to process each of the four types of claims (processing times) and the amount of work waiting to be processed (workloads pending)—we compared the performance of the 15 offices to (1) their performance levels 2 years earlier and (2) the performance of all offices nationally. While work pending decreased in most categories and most offices improved processing time for certain types of claims, overall the 15 offices as a group did not experience changes as favorable as those realized by all offices nationally. With certain exceptions, for most of the 15 offices, when performance declined, it declined more than the national average, and when it improved, the improvement was less than the national average.

Processing Times

At the 15 offices, processing times were longer for SSI-B/D and DI claims and shorter for RSI and SSI-Aged claims as of September 30, 1986, compared to 2 years earlier. Table 4.1 lists and compares the processing times for initial claims for fiscal years 1984 through 1986 and the percentage change since September 30, 1984.

Table 4.1: Mean Processing Times for Initial Claims for the 15 Offices Visited by GAO

Processing times in days

	Fiscal year			Average 1984-86	
Claim type	**1984**	**1985**	**1986**	**Days**	**Percent**
RSI	22.0	21.4	20.8	−1.2	−5.5
DI	72.8	73.0	88.1	+15.3	+21.0
SSI-Aged	15.3	12.6	10.1	−5.2	−34.0
SSI-B/D	74.3	72.7	97.4	+23.1	+31.1

Appendixes IV through VII show the mean processing times, by type of claim, for each of the 15 offices we reviewed.

Comparing these processing time changes to data at the national level shows that although RSI and SSI-Aged claims processing time has improved, overall the performance of the 15 offices has been less than the national average for 3 of the types of claims processed. Table 4.2 compares the percentage change in processing times for the two groups.

Table 4.2: Comparison of Changes in Mean Processing Times for Initial Claims—All Field Offices[a] vs. 15 Offices Visited

Processing times in days[b]

	1984		1986		1984 to 1986	
Claim type	**All**	**15**	**All**	**15**	**All**	**15**
RSI	24	22	21	21	−3	−1
DI	70	73	81	88	+11	+15
SSI-Aged	12	15	10	10	−2	−5
SSI-B/D	74	74	78	97	+4	+23

[a] Includes the 15 offices visited

[b] Rounded

The table shows that with one exception, the performance in processing times for the "all field offices" group was better than that for the 15 offices. For SSI aged claims, the 15 offices decreased processing times 5 days while nationally the decrease averaged 2 days. From the standpoint of service to the public—comparing the performance of the 15 offices with that of all offices nationally—we believe the 23-day increase in processing times for SSI-B/D claims represents a significant deterioration in service.

As mentioned earlier, SSA processing time data for disability related claims includes the time the claims are with state disability agencies. To determine to what extent state agencies with long processing times were influencing the 23-day increase in processing times for SSI-B/D claims, we excluded the times for the four offices located in New York and the one located in New Jersey. Both states historically have had long processing times; in fiscal year 1986, New York had the longest processing time with 109 days while New Jersey had the third longest time with 103 days. Excluding the 5 offices in New York and New Jersey, the claims processing time for the remaining 10 offices decreases significantly—from 97 days to 79 days, only 1 day above the national average.

Pending Workloads

Overall the amount of time required to process workload backlogs increased by 8.6 percent for the nine workloads we analyzed. To determine the change in workloads pending for these 15 offices, we compared September 30, 1983, pendings with pendings as of September 30, 1986. In making our comparison—because the unit time to process individual workloads varies—we weighted each workload by its unit time. (Unit time refers to the average amount of time used to process one item of a workload.) Because productivity varies by year and by region, we applied appropriate yearly and regional unit times to the individual workloads.

To illustrate, for the Schenectady, New York, office, for RSI claims pending, we applied a weight of 4.9 hours to the 89 claims pending at the end of fiscal year 1983, and a weight of 4.1 hours to the 76 claims pending at the end of fiscal year 1986. The difference between the products (436 and 312) yields the net change in the amount of time required to process this pending workload in this office. We performed similar analyses for the nine major workloads for all 15 offices and aggregated the results, which appear in table 4.3.

Table 4.3: Comparison of Work on Hand for Nine Workload Categories

Work on hand in hours

	Fiscal year		Percent change,
Workload category	**1983**	**1986**	**1983-86**
RSI claims	4,675	3,342	−29
RSI dependent claims	2,130	1,961	−8
DI claims	15,142	23,270	+54
SSI-Aged claims	624	250	−60
SSI-B/D claims	18,450	23,718	+29
Representative payee actions	399	453	+13
SSI/overpayments	4,637	1,514	−67
RSI and DI overpayments	1,728	1,041	−40
SSI/redeterminations	5,745	2,573	−55
Total	**53,530**	**58,122**	**+8.6**

The table shows that the time needed to process pending work in the 15 offices decreased for six of the nine workloads. The 8.6 percent increase was caused primarily by the relatively high volume and high weight (high unit times) of DI claims and SSI-B/D claims. Comparing the 8.6-percent increase to the change in pendings for all field offices (excluding the 15 we visited) for the same workloads shows the total number of hours required to process pending workloads decreased by 12.6 percent.

In examining the performance of the 15 individual offices, we found that 10 offices had increases in total hours of work pending. Of the other 5 offices which had decreases in total hours of work pending, 2 had decreases less than the 12.6-percent decrease nationally, and 3 had a greater decrease.

In terms of service to the public, increases in work on hand generally are indicative of increased processing times and, as can be seen, the increase in work on hand for the DI and SSI-B/D claims correspond to the increase in processing time for these claims shown on page 39.

From an operational standpoint, it appears that the 8.6-percent increase in work on hand over 3 years is relatively small. In comparison to work processed, the 8.6-percent increase represents less than 1 percent of the time it took these offices to process these nine workloads in fiscal year 1986.

Chapter 5

Extent of Past and Planned Staff Reductions

SSA's work-year use declined by 7,972 work-years, or about 9 percent of total work-years between fiscal years 1982 and 1986. Most of the decline occurred in fiscal years 1985 and 1986, the first 2 years of SSA's 6-year staff reduction program.

In SSA field offices—which account for over half of SSA's staff resources—staffing level changes have varied widely. Since 1984, 58 percent of field offices experienced staff losses, while 14 percent experienced no change in staffing and 28 percent had staff increases. Field office positions with the greatest proportion of staff loss are clericals and data review technicians.

In fiscal year 1987—to meet budgetary shortfalls totalling $284 million or 7.1 percent of its budget request—SSA reduced its work-years estimate by 5,266 below the work-year ceiling approved by the Congress. While SSA has a $160 million contingency reserve that could be used to compensate for this shortfall, SSA opted not to use it. SSA said, however, it will monitor service closely and use the reserve to increase staff resources, if necessary.

In its fiscal year 1988 budget submission, SSA is proposing a reduction of 2,454 FTE work-years for the RSI, DI, and SSI programs. Such a reduction would provide a total reduction of 10,606 FTE work-years through the first 4 years of the staff reduction program. Details on reductions of 6,400 planned beyond 1988 are not well defined as of March 5, 1987.

A 5-Year History of SSA Staff Changes

From fiscal years 1982 to 1986, SSA's total work-year usage dropped 9 percent—from 87,197 to 79,225 work-years. Table 5.1 shows this decline, by work-year category.

Table 5.1: SSA Work-Years by Type[a]

Work-year category[b]	1982	1983	1984	1985	1986	Percent 1982-86	Change 1984-86
FTE's	82,575	82,940	80,455	78,221	75,964	−8.0	−5.6
Overtime	2,824	3,992	4,017	2,331	1,492	−47.2	−62.9
Nonceiling	1,798	1,808	1,821	1,615	1,769	−1.6	−2.9
Total	**87,197**	**88,740**	**86,293**	**82,167**	**79,225**	**−9.1**	**−8.2**
Cumulative percent change	•	+1.8	−1.0	−5.8	−9.1		

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[a] Includes all programs administered by SSA. Excludes programs transferred out of SSA during the 1982-86 period.

[b] Full-time Equivalents (FTEs) consist of both full-time and part-time personnel whose employment is subject to ceilings set by the Office of Management and Budget and the Department of Health and Human Services. Nonceiling personnel are employees in special programs, such as stay-in-school and summer aide.

The table shows the greatest loss occurred in FTE work-years, which generally declined steadily since 1982. Conversely, overtime use during the period varied significantly by year.

Staff on duty for major SSA operational components generally declined steadily between the end of fiscal year 1982 and the end of fiscal year 1986. Table 5.2 shows end-of-year staffing figures for major SSA organizational components.

Table 5.2: Staff on Duty at End of Fiscal Year for Major SSA Components

						Percent	
Component	**1982**	**1983**	**1984**	**1985**	**1986**	**1982-86**	**1984-86**
SSA field offices	43,702	41,871	40,551	40,483	39,211	−10.3	−3.3
OHA hearing offices	4,870	4,949	4,534	4,352	4,283	−12.1	−5.5
PSCs[a]	14,390	14,563	14,154	13,495	12,279	−14.7	−13.2
OCRO[b]	5,310	4,888	5,091	5,642	4,642	−12.6	−8.8
ODO[c]	6,159	5,931	5,627	5,314	4,835	−21.5	−14.1
Total	**74,431**	**72,202**	**69,957**	**69,286**	**65,250**	**−12.3**	**−6.7**

[a] Program service centers

[b] Office of Central Records Operations

[c] Office of Disability Operations

The table shows that staffing levels of all major components declined an average of about 12 percent from fiscal year 1982 to fiscal year 1986. From fiscal year 1984 (the year before SSA's staffing reduction initiative began) to fiscal year 1986, SSA field offices experienced the lowest proportionate loss of staff (3.3 percent) while the PSCs and ODO experienced the largest reductions. The staff on duty by region for the 1982-86 period for the OHA hearings offices and the PSCs are shown in appendixes VIII and IX, respectively.

Staff Changes in Field Offices

Table 5.3 shows end-of-year staff on duty for SSA field offices, by region, for fiscal years 1982-86.

Table 5.3: Field Office Staff on Duty by Region[a]

	End of fiscal year					Percent change	
Region	**1982**	**1983**	**1984**	**1985**	**1986**	**1982-86**	**1984-86**
Boston	2,065	2,033	2,057	2,020	1,891	−8.4	−8.1
New York	6,121	5,875	5,550	5,496	5,231	−14.5	−5.7
Philadelphia	4,334	4,045	4,057	3,998	3,754	−13.4	−7.5
Atlanta	7,211	6,904	6,713	6,694	6,658	−7.7	−0.8
Chicago	7,815	7,567	7,202	7,312	7,121	−8.9	−1.1
Dallas	4,490	4,360	4,300	4,363	4,186	−6.8	−2.7
Kansas City	2,062	1,960	1,822	1,818	1,790	−13.2	−1.8
Denver	1,090	1,041	1,004	1,049	1,021	−6.3	+1.7
San Francisco	7,048	6,694	6,528	6,362	6,211	−11.9	−4.9
Seattle	1,466	1,392	1,318	1,371	1,348	−8.0	+2.3
Total	**43,702**	**41,871**	**40,551**	**40,483**	**39,211**	**−10.3**	**−3.3**

[a] Excludes regional headquarters staff

Overall, table 5.3 shows that field office staffing decreased 10.3 percent for the 1982-86 period and declined 3.3 percent for the 1984-86 period. On a regional basis, the table shows that change in staff for the fiscal year 1982-86 period varied from a decrease of 6.3 percent for the Denver region to a decrease of 14.5 percent for the New York region.

To determine the change in staffing levels of individual field offices, we developed office-level staffing information for the period beginning fiscal year 1984 through the end of fiscal year 1986.

Of the 1,309 SSA field offices in continuous operation during fiscal years 1984 to 1986, 58 percent experienced a net reduction in staff as of the end of fiscal year 1986, 28 percent had a net staff gain, and staff levels in 14 percent remained unchanged. These data are based on end of fiscal year staff on duty. Table 5.4 summarizes these changes.

Table 5.4: SSA Field Office Staff Changes[a]

Offices with	**Number**	**Percent of offices**
No change in staffing	187	14
Increased staffing	366	28
Decreased staffing	756	58
Total	**1,309**	

[a] Excludes staff in SSA's 34 teleservice centers and offices that opened or closed during the period

Of the field offices that had a net loss of staff between the start of fiscal year 1984 and the end of fiscal year 1986, 26 percent lost only one staff person. Table 5.5 shows the distribution of offices that experienced a decline in staffing by the number of net staff lost.

Table 5.5: Distribution of Field Offices by Number of Net Staff Lost (Fiscal Years 1984-86)

Staff Loss	Number of offices	Percent of offices
1	195	26
2	182	24
3	108	14
4	63	8
5	53	7
6	33	4
7-10	65	9
11-20	47	6
21-30	10	1
Total	**756**	**100**[a]

[a] Does not add due to rounding

In terms of the proportion of staff loss, 52 percent of the offices that lost staff experienced losses of 10 percent or less of their staff on duty at the start of fiscal year 1984. Twelve percent of offices that lost staff lost over 20 percent. Table 5.6 shows the distribution of offices that lost staff by percentage of staff loss.

Table 5.6: Distribution of Field Offices by Percent of Net Staff Lost (Fiscal Years 1984-86)

Percent of staff loss	Number of offices	Percent of offices
5 or less	119	16
Over 5 to 10	271	36
Over 10 to 15	161	21
Over 15 to 20	115	15
Over 20	90	12
Total	**756**	**100**

The change in field office staff mix for the period fiscal year 1982 to fiscal year 1986 is shown in table 5.7.

Table 5.7: SSA Field Office Staff Composition (Staff on Duty at End of Fiscal Year)

Type of position	Fiscal year 1982	Fiscal year 1984	Fiscal year 1986	Percent change 1982-86	Percent change 1984-86
Administrative	2,172	2,172	2,125	−2.2	−2.2
Operations supervisors	2,651	2,711	2,634	−0.6	−2.8
Operations analysts	532	467	405	−23.9	−13.3
Field representatives	1,250	1,175	1,088	−13.0	−7.4
Generalist claims representatives	1,383	1,132	1,469	+6.2	+29.8
Title II claims representatives	6,794	6,368	6,333	−6.8	−0.5
Title XVI claims representatives	5,970	6,199	5,725	−4.1	−7.6
Claims representative trainees	280	119	289	+3.2	+142.9
Data review technicians	4,317	3,960	3,062	−29.1	−22.7
Service representatives	6,608	6,410	6,053	−8.4	−5.6
Clerical	7,834	5,913	5,838	−25.5	−1.3
Other clerical	2,600	2,338	2,245	−13.7	−4.0
Special employment	1,307	1,587	1,243	−4.9	−21.7
Service representative/data review technician	[a]	[a]	703	[a]	[a]
Total staff on duty at end of year	**43,698[b]**	**40,551**	**39,212[b]**	**−10.3**	**−3.3**

[a] Not applicable

[b] The differences in these totals and those in table 5.3 are due to uncorrected SSA systems input errors.

Table 5.7 shows that the greatest proportionate loss of staff over the comparison period occurred among data review technicians (DRTS). This position is expected to be greatly affected by changes in claims processing resulting from the direct systems input of claims data which is to occur under the Claims Modernization Program. In anticipation of the planned elimination of the DRT position, in fiscal year 1985 SSA established a joint service representative/DRT position. As the table shows, 703 DRTS were listed in this position at the end of fiscal year 1986.

SSA field offices have also lost a significant proportion of clerical staff. Clericals on duty declined 25.5 percent from the end of fiscal year 1982 to the end of fiscal year 1986, and "other clericals" declined by 13.7 percent.

The number of generalist claims representatives on duty in SSA field offices increased from the end of fiscal year 1982 to 1986. Generalist claims representatives take applications for both RSI and SSI claims. SSA officials attributed the increase in the number of generalists to the need for increased staff flexibility, particularly in smaller offices.

Actions Taken to Implement Fiscal Year 1987 Budget

SSA's fiscal year 1987 budget plans were significantly affected by two events—an unanticipated congressional reduction of $171.3 million from the administration's appropriation request, and $112.7 million in unbudgeted costs resulting partly from the recent federal pay raise and the change in the federal retirement program. Together, these events resulted in a shortfall of $284 million, or 7.1 percent of SSA's initial appropriations request.

In its fiscal year 1987 budget submission, the administration requested just over $4 billion for the Limitation on Administrative Expense (LAE) account,[1] including $160 million for a contingency reserve to cover unanticipated workloads and other expenses. The administration estimated its total employment needs for the LAE account to be 78,580 work years, of which 73,270 were FTE work-years. The request reflected a reduction of 2,899 FTE work-years from the levels SSA expected to use in fiscal year 1986.

In separate but identical actions, the Senate and the House Appropriations Committees approved in total the over $4 billion and 78,580 work-years requested. Both, however, expressed the view that overtime—at 4.5 percent of LAE work-years—was too high and should be reduced to 3 percent of total work-years. To achieve an overtime level of 3 percent and at the same time approve the total work-years requested, both chambers increased FTEs by 1,167 to offset and equal a reduction in overtime work-years to 3 percent of total work-years. The change to SSA's fiscal year 1987 work-year mix is shown in table 5.8.

Table 5.8: Comparison of Work-Years Requested With Work-Years Approved
(Fiscal Year 1987)

	Budget request	Congressional action
FTEs	73,270	74,437
Overtime	3,524	2,357
Nonceiling	1,786	1,786
Total	**78,580**	**78,580**

In conference, the Appropriations Committees reduced SSA's LAE budget $171 million below the requested level. The conference report (99-960), dated October 2, 1986, explained the reduction as follows:

> "Last month, the conferees were informed by the Social Security Administration that they expect to lapse at least $171,000,000 in FY 1986. This results from a

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[1] Includes the RSI, DI, and SSI programs only.

> number of factors including lower outlays in their computer modernization project, lower use of overtime by Social Security field personnel and the carryover effect of overestimating requirements for FY 1985. This means that the 1986 base used by the executive branch and reviewed by the Congress in making its initial recommendation for FY 1987 was overstated. This is the basis for the reduction recommended by the conferees. This does not change any of the substantive recommendations of the House or Senate related to staffing or office closings, but merely reflects a reestimate of the amount of funding necessary to implement these recommendations. The conferees note that the contingency reserve of $160,000,000 has not been reduced and is available if necessary."

To compensate for the $171 million appropriations reduction, SSA made a number of budget reductions, including

- $24 million in payroll costs resulting from lower than expected average salaries;
- $34.3 million in FTE, nonceiling, and overtime work-year reductions;
- $78.5 million in controllable nonsalary cost reductions; and
- $37 million achieved by holding state disability agencies' spending at the fiscal year 1986 level.

SSA's fiscal year 1987 resources were further affected by unbudgeted costs of $94 million resulting from the costs of the 3-percent federal pay raise, which went into effect in January 1987, and the costs of the new Federal Employees' Retirement System. A December 15, 1986, memorandum from the SSA commissioner detailed SSA's adjustments for the $94 million in unbudgeted costs. These adjustments included

- reducing overtime work-years for January to September 1987 by two-thirds (saving $22 million);
- reducing nonceiling work-years for January to September 1987 by two-thirds (saving $7 million); and
- holding certain nonsalary controllable costs at 53 percent of fiscal year 1986 actual or fiscal year 1987 budgeted levels, whichever was lower (saving $65.6 million).

The cumulative effect of the reduction in SSA's appropriation and the unbudgeted costs on fiscal year 1987 work-year resources compared to fiscal year 1986 usage is shown in table 5.9.

Table 5.9: SSA FY 1987 Work-Year Operating Budget Compared to FY 1986 Usage and FY 1987 Appropriated Levels (LAE Only)

Work-year category	FY 1986 usage	FY 1987 appropriation	FY 1987 operating budget	Difference: 1987 appropriation less 1987 budget
FTE	75,494	74,437	71,799	2,638
Overtime	1,487	2,357	774	1,583
Nonceiling	1,615	1,786	741	1,045
Total	**78,746**	**78,580**	**73,314**	**5,266**

As table 5.9 shows, SSA's work-year fiscal year 1987 resources have been significantly affected by the budgetary shortfalls. SSA's 1987 operating budget is 5,266 work-years below the level appropriated by the Congress.

SSA chose to reduce its work-year use by 5,266 rather than use contingency reserve resources to make up the unanticipated budgetary reductions. SSA officials said they plan to manage for the remainder of the fiscal year under current resource allocations, but will consider drawing on the contingency reserve if serious service deterioration problems develop.

We did not review the bases for how SSA expected to achieve the additional 5,266 work-year reduction in fiscal year 1987. On December 9, 1986, we asked SSA for work-year savings estimates for all procedural and systems changes budgeted for implementation in fiscal year 1987 but as of March 1, 1987, SSA did not provide the information requested. Additional details on fiscal year 1987 reductions were contained in the fiscal year 1988 budget justification, a copy of which was provided to us on February 18, 1987. The justification, however, does not contain the level of detail required to perform an adequate analysis.

SSA's final fiscal year 1987 work-year allocations to its major components are shown in Table 5.10.

Table 5.10: FY 1987 Work-Year Allocations Compared to FY 1986 Use

Component	FY 1986 use	FY 1987 allocation	Percent difference
SSA field offices[a]	42,022	39,333	−6.4
OHA	5,516	5,435	−1.3
Office of Central Operations[b]	23,694	21,061	−11.1

[a] Includes regional office headquarters staff.

[b] Includes program service centers, disability operations, and central records operations.

As table 5.10 shows, components of SSA's Office of Central Operations (the program service centers, Office of Disability Operations, and Office of Central Records Operations) will experience the greatest proportionate decline in work-year resources—11.1 percent. SSA's field offices will experience a 6.4-percent reduction below fiscal year 1986 usage levels.

Table 5.11 shows the change in work-years for all SSA regions for fiscal year 1987 compared to fiscal year 1986 usage, by work-year category.

Table 5.11: FY 1987 Work-Year Allocations for SSA Field Offices Compared to FY 1986 Use

	FY 1986 actual	FY 1987 revised	Percent change from FY 1986
FTEs	40,267	38,520	−4.4
Overtime	841	456	−45.8
Nonceiling	914	347	−60.9
Total[a]	**42,022**	**39,333**	**−6.4**

[a] Includes regional office headquarters staff.

As the table shows, total work-year resources available to SSA regions in fiscal year 1987 are 6.4 percent below fiscal year 1986 actual usage. Nonceiling personnel work-years will experience the greatest reduction—61 percent—while overtime work-years will decline 46 percent; FTE work-years will decline 4.4 percent.

To achieve the fiscal year 1987 reductions, SSA's fiscal year 1987 employment policy calls for

- a general freeze on hiring for staff/support positions;
- some replacement of FTE losses in field and hearings offices and OCRO;
- no replacement of "normal losses" in the program service centers and the Office of Systems, although losses in excess of normal levels may be replaced; and
- a total freeze on hiring by or transfers into ODO.

To help reach its headquarters support staff reduction goal—originally estimated at 2,000 FTES—SSA announced in January 1987 a two-phase program intended to place headquarters and other support staff who are at grades GS-12 and above in field and hearings office vacancies as they occur. The program provides for pay retention for affected employees and the costs of employee relocations.

Under the first phase of the program, eligible employees can volunteer for available field assignments, but are not required to relocate. This phase is expected to last at least through the end of fiscal year 1987. Under the second phase of the program, relocation will be mandatory. In this phase, SSA management will identify which employees it wants to reassign, and post them to field office vacancies. Employees who meet certain age and service requirements who do not want to be reassigned outside of their "commuting area" may opt for a discontinued service retirement.

Staff Reduction Plan on Schedule

SSA's actual and budgeted FTE reduction for fiscal years 1985 through 1988—the first 4 years of the staff reduction initiative—is generally on target with the original plan. Table 5.12 compares the original FTE reductions planned for fiscal years 1985 to 1988 to the actual reductions in fiscal years 1985 and 1986 and currently budgeted for fiscal year 1987 and 1988.

Table 5.12: Comparison of Planned and Actual FTE Reductions (LAE Only)

	FTE reduction[a]	
	Original plan	**Fiscal year actual**
1985	1,913	2,210
1986	1,689	2,247
1987	3,079	3,695[a]
1988	3,925	2,454[b]
Total	**10,606**	**10,606**

[a] Operating budget as of February 15, 1987

[b] Fiscal year 1988 budget submission

The table shows that—assuming that the fiscal year 1987 and 1988 estimates hold—SSA's staff reduction program will be on target at the end of fiscal year 1988. The table also shows that, compared to its original plan, SSA has realized, or expects to realize, larger FTE reductions in each of the first 3 years of the program, but expects lower than planned reductions in fiscal year 1988. A number of reasons account for the differences in each year, including workloads that did not materialize, the impact of Gramm-Rudman legislation, and unanticipated budgetary cuts.

Beyond fiscal year 1988, SSA officials told us that the specifics of how SSA will achieve additional staff reductions are not yet precisely defined. They said however that SSA still expects to achieve reductions through systems modernization, increased productivity, and various procedural changes.

Chapter 6

Conclusions

Overall SSA service has remained stable during the first 2 years of the staff reduction program. SSA's traditional performance measures continue to reflect improved or stable service and, for its part, the public perceives that it is receiving good service. While many SSA employees express negative views regarding staff reductions, they nevertheless generally view service as good to very good and the same or better than 3 years ago. Similarly, SSA's mid-level managers, most of who said their units had less staff than needed, nevertheless said they believed performance in their units had improved or remained stable over the last several years. In units which lost staff, most managers and employees believed the reductions had adversely affected the work of their unit; 16 percent of the managers and employees categorized the effect as significant.

We share the concern of SSA managers and employees regarding future staff reductions. Reducing an agency's staffing by about 21 percent over a 6-year period without adversely affecting service is likely to become more difficult as the reductions continue. To help ensure that realized reductions are not adversely affecting service, SSA must closely watch for early warning indicators such as increased workloads in affected offices. To help ensure that planned reductions will not adversely affect service, SSA must have a sound basis for deciding the size and type of staff needed at each location to process projected workloads.

Appendix I

National Mean Processing Times for Initial Claims (Last 5 Quarters)

Figures in days[a]

	December 1985	March 1986	June 1986	September 1986	December 1986
RSI[b]	21	21	20	21	20
DI	71	88	83	80	79
SSI-aged	11	11	10	10	11
SSI-B/D	65	84	81	80	80

[a] Rounded to nearest whole day

[b] Includes Health insurance workloads.

Appendix II

Regional Mean Processing Times for Initial Claims (December 1985 and 1986 Quarters)

Figures in days[a]

	RSI		DI		SSI-Aged		SSI-B/D	
Region	**12/85**	**12/86**	**12/85**	**12/86**	**12/85**	**12/86**	**12/85**	**12/86**
Boston	27	23	82	100	11	12	68	96
New York	22	21	102	124	13	11	96	125
Philadelphia	17	15	49	69	9	8	55	89
Atlanta	20	20	64	67	13	13	61	66
Chicago	18	17	76	79	8	8	62	77
Dallas	23	23	68	77	11	10	60	74
Kansas City	20	19	62	62	11	10	46	55
Denver	22	22	67	72	10	11	60	71
San Francisco	20	19	77	72	10	10	69	76
Seattle	20	18	64	74	9	12	55	81
National	21	20	71	79	11	11	65	80

[a] Days rounded to nearest whole day.

Appendix III

Regional Mean Processing Times for Appeals (Last 5 Quarters)

Figures in days[a]

Region	December 1985		March 1986		June 1986		September 1986		December 1986	
	R	H	R	H	R	H	R	H	R	H
Boston	73	143	113	166	109	151	96	151	90	170
New York	86	135	100	148	93	132	101	137	97	152
Philadelphia	42	159	65	202	66	209	64	209	58	201
Atlanta	46	139	61	166	51	158	49	157	47	170
Chicago	59	161	77	199	68	198	63	187	62	180
Dallas	49	159	70	185	58	181	56	186	51	191
Kansas City	59	155	68	171	57	168	56	176	51	168
Denver	53	162	75	176	59	190	60	172	63	169
San Francisco	66	168	69	196	65	197	63	193	67	198
Seattle	54	197	82	241	73	226	64	226	62	202
National	57	154	73	182	65	178	63	176	61	178

[a] Rounded up to nearest whole day

Legend R = reconsiderations
H = hearings

Appendix IV

RSI Claims Mean Processing Times for 15 Offices Visited by GAO

Times in days

	Fiscal year			Change 1984-86	
	1984	1985	1986	Days	Percent
SSA Region 2—New York:					
New Rochelle, NY	25.2	22.8	22.8	−2.4	−9.5
Jersey City, NJ	28.7	29.1	27.4	−1.3	−4.5
NYC (Brooklyn)—Bedford	27.8	23.7	27.9	+0.1	+0.4
NYC (Manhattan)—Downtown	26.0	27.7	31.1	+5.1	+19.6
Schenectady, NY	19.6	19.0	18.3	−1.3	−6.6
SSA Region 3—Philadelphia:					
Wilmington, DE	19.9	19.4	19.6	−0.3	−1.5
Philadelphia, PA (Kensington and Allegheny Aves.)	20.9	19.2	17.8	−3.1	−14.8
Baltimore, MD (West)	17.1	16.8	14.0	−3.1	−18.1
Altoona, PA	16.7	14.6	16.1	−0.6	−3.6
Martinsburg, WV	17.3	18.6	20.1	+2.8	+16.2
SSA Region 5—Chicago:					
Galesburg, IL	20.7	18.9	17.9	−2.8	−13.5
Peoria, IL	21.4	19.2	17.0	−4.4	−20.6
Detroit, MI (Conner Ave.)	29.2	25.4	26.9	−2.3	−7.9
Euclid, OH	19.1	19.2	13.8	−5.3	−27.7
Indianapolis, IN (West)	18.1	17.3	15.2	−2.9	−16.0
Overall mean time (15 offices)	22.0	21.4	20.8	−1.2	−5.5
Mean time—all offices nationally	24.1	22.4	20.8	−3.3	−13.7

Appendix V

DI Claims Mean Processing Times for 15 Offices Visited by GAO

Times in days

	Fiscal year			Change 1984-86	
	1984	**1985**	**1986**	**Days**	**Percent**
SSA Region 2—New York:					
New Rochelle, NY	88.2	93.3	114.5	+26.3	+29.8
Jersey City, NJ	89.7	94.8	123.0	+33.3	+37.1
NYC (Brooklyn)—Bedford	65.8	89.3	109.5	+43.7	+66.4
NYC (Manhattan)—Downtown	110.7	108.5	128.1	+17.4	+15.7
Schenectady, NY	76.5	92.1	107.5	+31.0	+40.5
SSA Region 3—Philadelphia:					
Wilmington, DE	63.2	62.3	70.2	+7.0	+11.1
Philadelphia, PA (Kensington and Allegheny Aves.)	38.7	32.9	40.8	+2.1	+5.4
Baltimore, MD (West)	63.1	53.7	69.9	+6.8	+10.8
Altoona, PA	52.4	53.6	72.9	+20.5	+39.1
Martinsburg, WV	59.0	49.5	71.7	+12.7	+21.5
SSA Region 5—Chicago:					
Galesburg, IL	66.3	79.7	79.9	+13.6	+20.5
Peoria, IL	64.2	71.6	75.3	+11.1	+17.3
Detroit, MI (Conner Ave.)	71.6	66.9	74.1	+2.5	+3.5
Euclid, OH	77.4	80.7	94.2	+16.8	+21.7
Indianapolis, IN (West)	112.7	86.5	88.8	−23.9	−21.2
Overall mean time (15 offices)	72.8	73.0	88.1	+15.3	+21.0
Mean time—all offices nationally	69.7	70.1	80.7	+11.0	+15.8

Appendix VI

Mean Processing Times for SSI-Aged Claims for 15 Offices Visited by GAO

Times in days

	Fiscal year			Change 1984-86	
	1984	**1985**	**1986**	**Days**	**Percent**
SSA Region 2—New York					
New Rochelle, NY	25.0	20.9	14.2	−10.8	−43.2
Jersey City, NJ	18.8	12.7	12.9	−5.9	−31.4
NYC (Brooklyn)—Bedford	11.7	7.0	7.5	−4.2	−35.9
NYC (Manhattan)—Downtown	24.6	16.9	8.9	−15.7	−63.8
Schenectady, NY	13.1	9.9	10.9	−2.2	−16.8
SSA Region 3—Philadelphia					
Wilmington, DE	17.2	22.0	13.7	−3.5	−20.3
Philadelphia, PA (Kensington and Allegheny Aves.)	11.0	9.1	6.1	−4.9	−44.5
Baltimore, MD (West)	10.6	9.1	5.9	−4.7	−44.3
Altoona, PA	9.5	6.4	5.6	−3.9	−41.1
Martinsburg, WV	12.7	10.3	20.6	+7.9	+62.2
SSA Region 5—Chicago					
Galesburg, IL	14.7	11.4	13.3	−1.4	−9.5
Peoria, IL	14.4	8.8	7.0	−7.4	−51.4
Detroit, MI (Conner Ave.)	13.3	8.4	9.2	−4.1	−30.8
Euclid, OH	7.3	9.2	9.6	+2.3	+31.5
Indianapolis, IN (West)	11.9	15.2	7.8	−4.1	−34.5
Overall mean time (15 offices)	15.3	12.6	10.1	−5.2	−34.0
Mean time—all offices nationally	15.4	12.2	10.4	−5.0	−32.5

Appendix VII

Mean Processing Times for SSI-Blind/Disabled Claims for 15 Offices Visited by GAO

Times in days

	Fiscal year			Change 1984-86	
	1984	1985	1986	Days	Percent
SSA Region 2—New York:					
New Rochelle, NY	91.1	84.0	109.2	+18.1	+19.9
Jersey City, NJ	87.4	89.0	120.2	+32.8	+37.5
NYC (Brooklyn)—Bedford	75.9	103.1	139.2	+63.3	+83.4
NYC (Manhattan)—Downtown	78.8	93.9	125.5	+46.7	+59.3
Schenectady, NY	61.7	78.2	104.5	+42.8	+69.4
SSA Region 3—Philadelphia:					
Wilmington, DE	86.3	65.4	71.4	−14.9	−17.3
Philadelphia, PA (Kensington and Allegheny Aves.)	54.8	56.1	98.9	+44.1	+80.5
Baltimore, MD (West)	83.2	65.8	105.1	+21.9	+26.3
Altoona, PA	53.6	52.9	87.1	+33.5	+62.5
Martinsburg, WV	60.7	41.4	75.4	+14.7	+24.2
SSA Region 5—Chicago:					
Galesburg, IL	51.8	59.4	68.4	+16.6	+32.0
Peoria, IL	58.8	66.7	67.2	+8.4	+14.3
Detroit, MI (Conner Ave.)	75.3	67.1	74.2	−1.1	−1.5
Euclid, OH	82.5	53.0	44.8	−37.7	−45.7
Indianapolis, IN (West)	101.4	77.9	81.7	−19.7	−19.4
Overall mean time (15 offices)	74.3	72.7	97.4	+23.1	+31.1
Mean time—all offices nationally	71.4	65.3	78.0	+6.6	+9.2

Appendix VIII

Office of Hearings and Appeals Staff on Duty by Region

	End of fiscal year					Percent change	
Region	**1982**	**1983**	**1984**	**1985**	**1986**	**1982-86**	**1984-86**
Boston	226	227	187	185	182	−19.5	− 2.7
New York	764	734	652	625	579	−24.2	−11.2
Philadelphia	519	532	484	465	439	−15.4	− 9.3
Atlanta	988	990	954	916	898	− 9.1	− 5.9
Chicago	812	870	792	760	776	− 4.4	− 2.0
Dallas	521	521	482	465	463	−11.1	− 3.9
Kansas City	193	197	183	174	170	−11.9	− 7.1
Denver	108	112	103	99	101	− 6.5	− 1.9
San Francisco	609	642	575	548	539	−11.5	− 6.3
Seattle	130	124	122	115	136	+ 4.6	+11.4
Total	**4,870**	**4,949**	**4,534**	**4,352**	**4,283**	**−12.1**	**− 5.5**

Note: Figures reflect regional chief administrative law judge and regional hearings office staffing only

Program Service Center Staff on Duty

PSC	End of fiscal year					Percent change	
	1982	**1983**	**1984**	**1985**	**1986**	**1982-86**	**1984-86**
North Eastern	2,299	2,367	2,244	2,103	1,850	−19.5	−17.6
Mid-Atlantic	1,977	1,986	2,010	1,929	1,794	−09.3	−10.7
South Eastern	2,433	2,406	2,317	2,228	2,071	−14.9	−10.6
Great Lakes	2,620	2,600	2,545	2,457	2,243	−14.4	−11.9
Middle America	2,730	2,766	2,696	2,590	2,365	−13.4	−12.2
Western	1,772	1,863	1,725	1,600	1,417	−20.0	−17.9
International	559	575	618	588	539	−3.6	−12.8
Total[a]	**14,390**	**14,563**	**14,154**	**13,495**	**12,279**	**−14.7**	**−13.2**

[a] Excludes central office support staff

ITEM 4

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STATEMENT BY THE ALLIANCE FOR AGING RESEARCH

BEFORE THE

U.S. SENATE SPECIAL COMMITTEE ON AGING

Honorable John Melcher, Chairman

March 13, 1987

STATEMENT BY THE ALLIANCE FOR AGING RESEARCH

Chairman Melcher and Distinguished Members of the Senate Special Committee on Aging:

The Alliance for Aging Research is grateful for the opportunity to present testimony on the Administration's budget request for fiscal year 1988.

In our testimony today we hope to convey to the Committee a sense of the growing excitement among researchers who are probing the riddles of human aging. New insights are emerging daily in areas of science that barely existed, or at best were poorly understood, just a decade ago. In the forefront of today's aging research is the banner of a new idea: that health and vitality might be the common blessing of the many at every stage of life. Scientists who are closest to the frontiers of gerontology believe the large scale achievement of lifetime health and vigor can be an attainable goal within the foreseeable future. In American society -- which will see the over-65 population double and the number of people over 85 more than triple in the next half-century -- a national commitment to aging research is prudent and necessary public policy. We will also relate the testimony of our organization to the matter before this Committee: consideration of the President's budget proposals for fiscal year 1988. In particular we will look at the fiscal impact upon the National Institutes of Health, especially those research areas which hold the greatest promise for intervening in the aging processes to maintain health and human capacity.

The Alliance for Aging Research is a private, non-profit, non-partisan organization established in 1986 to advance gerontology and preventive geriatrics in the national interest. Our Alliance unites some of the nation's premier science leaders, private sector executives and federal policy makers in joint efforts to raise the visibility and priority of aging research within the nation's science policies. We have undertaken to chart the rapid progress in scientific understanding of human aging, and to link continued progress to this nation's present policies and its future ability to cope successfully with a dramatically larger population of older Americans.

The Alliance for Aging Research has been formed when two important trends in our country are about to intersect: the so-called Senior Boom and the equally resonant explosion of new knowledge in the life sciences.

The Members of the Committee are well aware of the profound demographic transformation of our country and our world as a result of major increases in average life expectancy. Increased survival in this century -- together with a 25-year trend of birth rates below replacement level -- have produced the much-discussed "Graying of America."

The aging of the American population may be the guiding principle of our country's domestic affairs well into the 21st Century. In 1983, for the first time in our history, the number of people over 65 surpassed the number of people under 25. By the year 2030, it is estimated that the over-65 age group will outnumber all those between ages 18 and 35. Beyond 2030, the only significant growth in our population, according to officials in the Bureau of the Census, will be among the age group 80 and older. Their numbers, which presently are less than 6 million, will swell to 16 million in 2030 and to 26 million in 2050.

Many people now living will see an America in which the old and the very old will be the largest and still fastest growing segment of our society. At present, we have an incomplete understanding of disease and disability. We are in one sense victims of our own successes. Americans have reason to be thankful for the improvements in medicine, sanitation and public health that have led to an improved standard of living and dramatically higher life expectancy in the 20th Century. However, present technology is still short of maintaining good health throughout the lifespan. Although medical advances during the past 80 years have allowed increasing numbers of us to live many more years than our grandparents and parents, relatively little has been accomplished to ensure that we live out this increased period of life with full mental and physical health and vigor.

So far we have not found the answers to the litany of chronic ailments -- arthritis, Alzheimer's Disease, cataracts, Parkinson's Disease, deafness, diabetes, osteoporosis -- that can make the frail elderly wonder if their longevity is worthwhile.

Those with responsibilities for the wise use of federal funds must also wonder at the long term costs to society if continued increases in life expectancy mean stretching out the period of protracted dependency and physical and mental decline. People over 65 comprise 12 percent of the population today, and though only 5 percent of the elderly reside in nursing homes or hospitals, still this group consumes a third of the nation's health care resources. By the year 2000, it is estimated that 50 percent of all health care expenses will be related to the care and treatment of our over-65 population. It is clear that America could benefit greatly from increased numbers of healthy, long-lived citizens. It is equally certain that the nation could suffer a loss of profound magnitude if its growing older population is ill, functionally dependent, and socially impotent.

(5)

Scientific research is the fulcrum that can transform a larger population of elderly to a rich resource for productivity and renewal. Without the discovery and application of new knowledge, we remain trapped. Without solutions to broken minds as reflected in Alzheimer's Disease and broken bones as reflected in osteoporosis we destine great numbers of older persons to calamitous old age. Without a sustained commitment to research there will be increasing numbers of decrepit and dependent elders as society moves into the next century. Research breakthroughs, however, could reduce the duration and the extent of dependency before death. To markedly abbreviate dependency and maintain vigor is the central task of gerontology and geriatrics and social policies focusing on aging.

Aging research is a very "young" science. It was only in the late 1960s that scientists developed a laboratory model to determine the ticking of the biological clock in individual cells. In the past 10 years scientists and social researchers have begun to separate normal healthy aging from distinct pathologies such as dementia. We have now moved beyond the beginning period of gerontology and preventive geriatrics to a time of potential intervention, of prevention, treatment and rehabilitation of the many maladies of age, and even, in some measure, intervention into manifestations of the aging processes themselves.

The Alliance for Aging Research is monitoring scientific progress in these areas, and providing national leadership and the general public with an appreciation of the potential results. This organization presently is engaged in a survey of the American science leaders to illuminate some of the most promising avenues of current research in aging. This assessment of current research will be completed and made public this Spring. Already our survey of the aging field has yielded important markers of forward movement. Just since the 100th Congress convened two months ago, these developments have appeared in scientific literature:

> -- An important clue to the understanding of Alzheimer's Disease was discovered when scientists last month reported locating an abnormality on a protein of the 21st chromosome that causes the inherited form of the disease. This breakthrough will allow scientists to narrow the scope of research to focus efforts on the gene causing the disease.
>
> -- A program designed to give nursing home patients greater self control and self determination reduced mortality in a test group by 50 percent.

-- Hormonal therapy, notably estrogen treatments, were found recently to be far more effective than calcium supplementation in preventing early onset of the bone-thinning disease osteoporosis.

Beyond the headlines, there is a gathering excitement in the scientific community relating to a well established means to reset the biological clock. Fifty years ago its was shown that rats and mice placed on a diet complete with essential nutrients but drastically reduced in caloric content lived markedly longer and healthier lives than a control group that was free to eat without limit. The orginal experiment was repeated and refined over five decades with strikingly similar results. Caloric restriction in a clinical setting dramatically improves mortality, morbidity, protects the animal from tumors, slows the aging of the brain, and in other measurable ways lengthens and prolongs the youthful state. Now a new generation of researchers -- armed with a greater understanding of molecular genetics, immunology and nutrition -- are closing in on the fundamental mechanisms by which caloric restriction achieves its results. The survey now underway by the Alliance for Aging Research is turning up fervent interest by scientists across a half-dozen different disciplines in pursuing an understanding of basic factors triggered by caloric restriction.

They are eager to test the hypotheses of competing theories of aging against the caloric restriction model, and to move the studies to animals higher on the evolutionary ladder, eventually to humans. Of course it is impossible to predict how quickly this turn of events could produce findings that open the doors to breakthroughs. It is even harder to say when, or if, the longer, more youthful, less cancer-prone lives of the restricted laboratory animals will be available to human beings. But is clear that many avenues of inquiry that can be characterized as aging research are converging toward a few testable theories of how and why humans age as they do. From there strategies can be developed by physicians, psychologists, social scientists and others to intervene in disease processes and the aging processes themselves to postpone or prevent the decrements of advanced age.

What is know is that the ability of our scientific enterprise to arrive at answers will be slowed or stopped cold if our national leadership retreats from its traditional support for scientific research. Regrettably, the President's budget proposals now before Congress would have the effect of signaling such a retreat.

We understand that the Administration has proposed to extend to the end of fiscal 1988 the availability of slightly more than $334 million appropriated by Congress for the National Institutes of Health for fiscal 1987, and to obligate those funds only after October 1,1987.

Our analysis of that proposed extended availability of funds is that it would reduce the ability of the NIH to fund new and competing research grants by about 700 grants in 1987. With regard to aging research, the present momentum toward deeper understanding of aging will be seriously slowed if those grants are not awarded in neurology, immunology, oncology, research into heart and cardiovascular disease, arthritis, mental illness, hearing and vision research. Those studies are critical to coping with aging and all of them are carried out in large measure by NIH institutes outside of the National Institute on Aging. Within the NIA the proposed reduction would have a particularly debilitating effect on efforts to unravel the underlying mechanisms and causes of aging. The NIA is one of the newest of the NIH institutes and remains 10th out of 12 institutes when ranked by size of operating budget.

The proposed extension of available funds through fiscal 1988 would reduce the NIA's access to funds appropriated by the last Congress by about $11 million. The money would not be taken from contracts, intramural research centers, or from NIA internal operations. It would be cut from approved new and competing extramural research grants that are ready to begin. The number of NIA research project grants would have to be reduced to 173 in the current fiscal year, an overall drop of 32 grants from what was awarded in fiscal 1986.

In addition, the NIA would be forced to negotiate an across-the-board reduction in all its current research projects. Directors of other institutes in the NIH would have to do the same. The requirements for reducing current research would be even worse in fiscal 1988. In the NIA alone all grants would be negotiated down by some 16%. If this comes to pass it would be a body blow to the pace of vital research.

The Alliance understands that the Administration's carry-over plan will be opposed by some on Capitol Hill. This organization lauds those who will resist a short-sighted proposal that could cripple the scientific enterprise. To depress research budgets for aging and other health research priorities is a distortion of fiscal responsibility, and an inappropriate response to the nation's needs.

Senators on this Committee and others in Congress have shown they understand the implications of population aging and appreciate the need for an appropriate investment in scientific research to meet our common challenge. In its report on fiscal 1987 appropriations for the NIA, the Senate Appropriations for Labor/HHS stated:

> This demographic shift has created a major scientific challenge focused on defining the nature of the aging processes and obtaining and understanding of the mechanisms of age-related diseases and disorders.

To retreat now from such a stance -- and from the adopted 1987 appropriation of $177 million for the National Institute on Aging -- would be a costly mistake.

ITEM 5

American
Psychiatric
Association

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March 13, 1987

The Honorable John Melcher
Chair
The United States Senate
Senate Special Committee on Aging
G-33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Melcher:

On behalf of the American Psychiatric Association, a medical specialty society representing more than 33,000 physicians nationwide, I am pleased to provide comments on the Secretary of Health and Human Services Budget for fiscal year 1988. The APA is disturbed that the budget focus is large cuts in many domestic spending programs and makes no effort to establish a proven cost-effective investment by ending the historic discriminatory Medicare outpatient benefit for our elderly population with mental disorders. Ending this discrimination would provide patients with mental disorders with an alternative to inpatient treatment.

Our comments focus on programs under the Alcohol, Drug Abuse and Mental Health Administration and Medicare, but I must express extreme concern about all domestic spending cuts. The budget focus on large reductions in many domestic spending programs, will affect programs of vital importance to mentally disabled people and those addicted to alcohol and drugs. In the budget proposals for ADAMHA at best, programs are continued at current levels; at worst, they are callously eliminated. The President proposes reductions in research and research training, at a time in our history when a modest expansion in these areas is essential to capitalize on new knowledge about the brain and behavior. The budget seeks to circumvent the budget process and the recent HHS Appropriation Act by proposing to extend the availability of fiscal year 1987 research funds into fiscal year 1988. No growth is sought in service delivery activities, including those programs authorized by the historic Anti-Drug Act. An unjustified reduction is proposed for the new program of protection and advocacy services for mentally ill persons and for the NIMH Clinical Training Program. By reducing clinical training funds, important programs for geriatric psychiatry trainees may not be expanded and may be cut back. No funds are requested to implement a new state planning program. Staff support and direct operations activities are dangerously low.

While acknowledging the need to address budget deficits in light of the Gramm-Rudman-Hollings Balanced Budget Act, we do not believe human service programs should bear the heavy burden of further cuts. These programs have been "pared to the bone" already, and Congress must look at alternative means to control the federal deficit.

As we know the prevalence of mental disorders among the elderly ranges from 15-25% of the population, with Alzheimer's disease the most frequent diagnosis. Appropriate service delivery cannot be delivered to this population because of the lack flexibility of coverage. The Medicare psychiatric outpatient limit has remained at $250 dollars after copayment and deductible since the inception of the program and there is a 190 day lifetime hamper in psychiatric facilities. These limitations, in particular the outpatient one, severely limit the patient's ability to seek medically necessary care.

Interestingly, while a recent publicly disclosed draft Inspector General report inappropriately recommends a "cap" on inpatient psychiatric care it does so because this cap would encourage use of outpatient care. While the change might encourage outpatient use, the fact is the benefit is so limited that the beneficiary purchasing power is severely restricted. We were thus further surprised that neither the budget nor the Secretary of HHS's catastrophic insurance proposal and subsequent bills addressed the need to expand outpatient Medicare coverage for medically necessary psychiatric care -- even to the limited investment developed for Alzheimers Disease and related disorders.

Two Medicare budget proposals especially concern us. We feel that quality of care for patients will be severely disrupted by including any physicians' services in the hospital's DRG. This will then give the radiologists, pathologists and anesthesiologists or hospitals incentives to underserve patients. One prior proposal recommendation included all physicians' services in the hospital DRG. We do not wish to see budgetary concerns prevent patients from receiving all aspects of care they need. Further reductions to graduate medical education are also inappropriate at this time. For psychiatry, this burden would be especially onerous. Psychiatry is one of the few specialties in documented shortage in GMENAC and the psychiatric needs of our elderly population are expanding. Congress' original intent in Medicare legislation was to support graduate medical education. We hope you will continue to maintain this promise, so that our heatlh care system can remain one of the best in the world.

Please know we are appreciative of your efforts and those of the Special Aging Committee on behalf of those elderly individuals with mental disorders. We especially appreciate the fact that you are an original co-sponsor of S. 718 "The Medicare Mental Illness Non-Discrimination Act of 1987".

Sincerely,

Melvin Sabshin, M.D.
Medical Director

MS:JBC:ES:jdc

ITEM 6

Association
for Gerontology
in Higher
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TESTIMONY

OF

THE ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

ADDRESSING

THE EFFECT OF THE ADMINISTRATION'S

PROPOSED FY 1988 BUDGET ON OLDER AMERICANS

SUBMITTED TO

SPECIAL COMMITTEE ON AGING

U.S. SENATE

MARCH 13, 1987

Chairman Melcher and distinguished members of the Special Committee on Aging, this testimony is being submitted on behalf of the Association for Gerontology in Higher Education (AGHE). AGHE is a nonprofit membership organization of approximately 280 institutions of higher education that conduct research and provide education and training in the field of gerontology. This testimony addresses both the Administration's proposed FY 1988 budget as it effects older Americans, and provisions for the 1987 reauthorization of the Older Americans Act (OAA).

Title IV of the OAA - Background Information. The Title IV research, training, and demonstration programs, begun in 1966, are the only federally-supported programs designed to support applied research for the social/behavioral needs of older adults; to train personnel in non-health professions to work with the elderly; and to develop demonstration projects to serve as community models for service delivery programs for older Americans. The major programs currently funded under Title IV are research and demonstrations, gerontology training (including career preparation), training and demonstrations for legal service programs for the elderly, and support to national minority organizations.

Examples of Recently Funded Title IV Projects. The following information concerns three exemplary programs begun with AOA Title IV support which illustrate the wise investment of federal dollars in the long-range improvement of educational, research, and service delivery institutions.

(1) Enhancing the Quality of Gerontology Instruction is a

survey research project conducted this past year by this Association in conjunction with the Andrus Gerontology Center at the University of Southern California. It was designed to determine the extent and character of gerontology instruction in America's colleges and universities. It is the first attempt in ten years to conduct a national survey of gerontology programs, and it is the first time ever that a survey of this depth and scope has been undertaken. The investigation will provide information on courses taught in aging, numbers and characteristics of gerontology faculty, numbers of past and present gerontology students, funding sources for these programs, administrative structures, academic credentials offered in gerontology, relationships to traditional academic disciplines within the institution. The data base which this project has produced will have a broad and far-reaching impact on the future development of the field. It will enable informed planning to occur and appropriate targeting of limited resources.

(2) The National Data Base on Aging is a project initiated by the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (NAAAA) with funds from Title IV (OAA). It is a comprehensive, up-to-date information system dealing with statistics about the elderly and the services provided by the network on aging. Detailed information on the budgets, staffing, clients and services of State Units and Area Agencies on Aging are compiled. These service programs which operate in every county in the country include in-home care, nutrition, transportation, and other

activities that promote independence. The data base is updated annually and encompasses a wide range of information from numbers and characteristics of persons served, to units and costs of service provided.

(3) The Hispanic Gerontology Internship Program is designed to provide on-the-job and in-service training for Hispanics by placing them in full-time administratively responsible positions in public and private aging networks. The project is sponsored by the Associacion Nacional Pro Personas Mayores and is funded by the Administration on Aging. Interns receive a taxable salary and fringe benefits during their six month internship. Participation in the program provides training for qualified individuals to assume administrative/management positions within the aging network.

Maintaining Funding for OAA Title IV at an Adequate Level. As an association of educators AGHE is particularly concerned with maintaining adequate levels of funding for Title IV of the OAA which provides for so many important initiatives in the field of aging. During the tenure of this Administration, support for Title IV has been reduced by 54%, by far the greatest reduction of any OAA program. Specifically, the Title IV peek funding level of $54.3 million in FY 1980 has been reduced to $25 million in FY 1987. In fact, the budgetary recommendations of the Administration have been far below the current funding level which was supported by Congress. Indeed, the Administration recommended only $5 million for Title IV in FY 1984 and FY 1985. It is only in response to continued higher funding levels by Congress that the Administration in FY 1986 and FY 1987 raised the proposed amount to $12.5 million which is still far below an adequate funding level for such an important program. In yet another effort to reduce Title IV funding, the Administration has recently proposed the reprogramming of $12.5 million from Title IV to the Office of Human Development Services (OHDS) salary and expense account ($1,360,000) and Foster Care ($11,144,000) for the current fiscal year.

Whereas the Administration has persistently fought to reduce Title IV funding, Congress has consistently shown bi-partisan support for Title IV. While our nation has had to face a climate of fiscal austerity, Congress has continued to advocate for improving the lives of Americans of all ages by maintaining reasonable funding levels for education, training, and research programs sponsored by a number of Federal agencies. By maintaining funding for Title IV and other such programs, Congress has expressed its willingness to make an investment in the future and to reaffirm a federal responsibility for assuring the development of a research base and a supply of trained professionals in the field of aging.

Title IV a Necessary Complement to Title III. The actions of Congress have served to confirm the fact that the Title IV programs of training, research and demonstrations are a necessary complement to Title III supportive and nutritional services. It must be recognized that of equal value to service programs for older Americans are the (a) research activities which expand our knowledge about the aging process, (b) the demonstration projects which enable more appropriate and efficient service programs to be designed, (c) educational programs which prepare professionals to work in the field of aging, and (d) continuing education and training programs which upgrade the skills of persons already serving the elderly and their families.

Without these "supportive" programs the service delivery activities will most likely be ill-conceived and inappropriate and will be staffed by persons who do not understand the aging process, how to work effectively with older adults and their families, or how to be efficient administrators. The adage, "If you think education is expensive, try ignorance," is all too true. The waste of fiscal and human resources which occurs when planning is uninformed and personnel are untrained is an unfortunate reality. Private industry would never manufacture a product without the backing of research. The Defense Department would never operate the machinery of modern warfare without trained personnel. The health and social service arena is in no less need of a knowledge base and an educated and trained manpower.

Recommendations for the 1987 Reauthorization of the Older Americans Act. We urge Congress to continue its support of programs dealing with research, training, and demonstrations in the field of aging. With regard to the 1987 reauthorization of the OAA, we do not recommend major changes to the Act, which has served well our nation's elderly for twenty-one years. However, there are several "fine tuning" or "corrective" changes which would clarify the intent of Congress and strengthen the Act.

This Association's specific recommendations for reauthorization are stated in the position of the Title IV Coalition (Attachment #1) which has already been sent to several members of Congress.

Recommendations on FY 1988 Budget. AGHE urges Congress to continue funding Title IV of the OAA at least at the current level of $25 million in the FY 1988 budget. In past years Title IV experienced drastic funding reductions and therefore could not withstand any further budgetary cuts at this time.

AGHE encourages continued support by the National Institute on Aging (NIA) for research and education efforts in the behavioral/social sciences. Since budgetary constraints will necessarily force the level of the OAA Title IV funding to remain at a significantly reduced level, the amount of federal resources devoted to behavioral/social science research has been greatly diminished. For this reason, it is more important than ever that other appropriate Federal agencies such as NIA support the aging research, education, and training programs in behavioral/social sciences.

Finally, we call upon Congress to appropriate funds for the systematic collection of manpower data in the field of aging. Congress has on several occasions requested from various agencies (AOA, HRSA, NIA) reports on future personnel needs for the field of aging. The reports which have so far been submitted to Congress on manpower reveal that there are considerable gaps in our knowledge. While the necessary questions regarding personnel needs are being posed, appropriate and valid answers can not be provided without funding for the development of an ongoing and coordinated data base that will provide manpower guidelines for the field of aging. The best use of Federal, state, local, and private funds in the area of personnel training in the field of aging will only be made when current, comprehensive, valid, reliable manpower research is available.

ATTACHMENT #1

TITLE IV COALITION'S
POSITION ON THE 1987 REAUTHORIZATION OF THE OLDER AMERICANS ACT

This position is supported by the following organizations:

American Association of Homes for the Aged
American Association of Retired Persons
American Society on Aging
Asociacion Nacional Pro Personas Mayores
Association for Gerontology in Higher Education
Gerontological Society of America*
National Caucus and Center on Black Aged, Inc.
National Council of Senior Citizens
National Farmers Union
National Pacific/Asian Resource Center on Aging.

I. Older Americans Act in General

A. At least a three-year reauthorization. All Older Americans Act programs should be extended for at least three years, through 1990.

B. Simple reauthorization, with minor adjustments. We do not recommend major changes to the Act, which has served well our nation's elderly for twenty-one years. However, there are several "fine-tuning" or "corrective" changes which would clarify the intent of Congress and strengthen the Act.

C. Increased authorization levels. Funding for all titles of the OAA, including Title IV, should be increased at least 5% to meet the growing demand for services and programs authorized under this Act and the increasing cost of implementing these programs.

D. Increase the authority of the Commissioner on Aging by having the Commissioner report directly to the Secretary of HHS rather than to the Office of the Secretary. The subordinate position of the Commissioner within OHDS has historically decreased the effectiveness of the Commissioner in serving as a strong advocate for the Older Americans Act programs and in having control over and accountability for AoA's directions and priorities.

II. Title IV

A. Oppose any attempt to consolidate Title IV programs. In the 1981 reauthorization of the OAA, the statutory language for

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*The Gerontological Society of America has no position on the following portions of this document: I.D., II.B., II.D..

Title IV was significantly edited and consolidated, and the rationale for that consolidation was the same as provided for the 1987 proposal. Because of the negative impact on Title IV programs which resulted from the 1981 revisions, Congress de-consolidated Title IV in the 1984 reauthorization, restoring clarity and precision to the language, spelling out the purposes of specific Title IV programs and indicating which historically successful programs should be continued. Any attempts to revert to the 1981 language should be vigorously opposed.

B. Separate program announcements for availability of funds and request for applications. Prior to 1981 there was a separate program announcement for the Administration on Aging's discretionary programs which clearly stated the priorities of AoA and the aging program categories to be funded for that particular year. The OHDS coordinated discretionary funds program announcement initiated in 1981 has resulted in a diluting of the OAA discretionary programs, in a reduction of the Commissioner's role in establishing priorities for AoA's discretionary programs, in a decreased accountability for the Title IV programs by the Commissioner, and in less clarity as to the Administration's goals and priorities for aging programs. A return to a separate program announcement would allow for continued coordination with other OHDS agencies and yet would strengthen the OAA discretionary programs.

C. Line-item authorization for key components of Title IV. In the three years since the OAA was last reauthorized, the Administration has not only attempted to reduce funding for Title IV, but has funded very disproportionately the various activities of Title IV authorized by the OAA. For example, education and training programs have been dramatically curtailed, and research has all but been eliminated. A line-item authorization would clarify the intent of Congress regarding the continuation of key components of Title IV and would result in line-item appropriations for these areas.

D. Support current law which authorizes the Commissioner to make grants and enter into contracts with public and private non-profit agencies, organizations, or institutions to support the development of programs funded under Title IV. For-profit organizations would undoubtedly be in a position to "under-bid" many non-profit organizations and institutions, effectively eliminating the participation of most educational institutions, community-based agencies and other non-profits from participation in the Older Americans Act discretionary programs. The entry of for-profits into unrestricted take-over of OAA Title IV programs would be a penny-wise pound-foolish response to the need to provide low-cost services, while at the same time being concerned with quality of services and long-term institutional and organizational commitment to the welfare of older Americans.

E. Title IV proposals may be submitted by a wide range of public and non-profit agencies, organizations, and institutions without receiving prior clearance from state and area agencies on aging. Congress should make clear in the 1987 Older Americans Act amendments--preferably statutorily (if not by statute, then in the accompanying report)--that the Administration on Aging may seek comments from state units and area agencies on aging concerning applications for Title IV funding by colleges, universities, national organizations, and others when the proposals relate directly to service delivery in their respective jurisdictions.

F. Inclusive definition of the "aging network" and the "field of aging". The key components of the "aging network" and the "field of aging" are state units on aging, area agencies on aging, national aging organizations, colleges and universities, service providers, and other organizations, agencies, and institutions involved in providing services and programs to older persons and in conducting training, education, and research in aging. Congress should clarify the fact that when the terms "aging network" and the "field of aging" are used in the Older Americans Act or by the Administration on Aging, these terms should have broad application and should include all of the key component groups mentioned in this section.

G. Promotion of career preparation training for minorities. Amendments to the OAA should refer to the promotion of career preparation training for minorities. This emphasis is needed to attract more minorities into the field of aging.

ITEM 7

STATEMENT

OF

THE GERONTOLOGICAL SOCIETY OF AMERICA

SUBMITTED TO

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ADDRESSING

THE IMPACT OF THE ADMINISTRATION'S PROPOSED FY '88 BUDGET ON NIA

March 13, 1987

Chairman Melcher and distinguished members of the Senate Special Committee on Aging, we appreciate the opportunity to submit to you our testimony on the impact of the Admininstration's proposed FY 1988 budget on the research and training activities of the National Institute on Aging.

The Gerontological Society of America is a national, scientific organization of researchers, educators, and other professionals in the fields of biology, clinical medicine, the behavioral sciences, and social research, policy analysis and planning. A major concern is the development and application of knowledge in all aspects of aging.

The National Institute on Aging has made major strides since its creation in 1974. Most recently, the Institute has spearheaded a national research effort on the many aspects of Alzheimer disease and other dementing disorders, including funding ten special Alzheimer Disease Research Centers throughout the country to coordinate multidisciplinary investigations. These investments have already led to exciting new discoveries about the diagnosis, treatment, and etiology of Alzheimer disease, leading us ever closer to the cause of this dreaded disease.

NIA has made significant research advances in other areas including urinary incontinence, and hip fractures, as well as providing a better understanding of "normal" biological and psychological aging and of changes that occur with age but that are a result of disease or other external environmental factors. These research advances have led to increased knowledge about and treatment of some of the chronic diseases prevalent among older persons.

Normal Aging

Congress and the public have an understandable tendency to focus on disease-related research, but learning about normal aging is just as, if not more, important than understanding diseases which afflict older people.

An obvious example of why understanding normal aging is so important is illustrated by the following. For years, older people with any of a broad group of symptoms were diagnosed as "becoming senile, a natural result of growing old." People were told to accept their condition.

Today, we know that senility is not part of normal aging, that some of the symptoms associated with normal aging are reversible, and that research on the diseases which currently are not reversible has increased dramatically.

Clearly, understanding of normal aging is crucial to identifying diseases to be studied and to learning ways to prevent, cure, or treat those diseases. Equally, if not more important, an understanding of normal aging is crucial to identifying accurately the contributions older people, now defined as those 65 and over, can continue to make to society, which in turn will help Congress and other decision makers to devise policies more responsive to the opportunities and challenges presented by the extension of life expectancy. Looking ahead, one would guess that the more we learn about normal aging, the less important the arbitrary age of 65 will become.

These points are made to stress the importance of and potential benefit from research on normal aging. As important as disease-related research, we should not, we must not, ignore basic research in the aging process.

Incidence and Costs of Selected Chronic Diseases

A quick glance at the incidence and costs of a few of the chronic diseases most common to older people makes a compelling case why our investment in research is so critical to the future health of this nation.

Alzheimer disease affects 5-15 percent of those over age 65 (currently 1.2 to 4 million Americans), and accounts for an estimated 30-50 percent of those entering a nursing home (Office of Technology Assessment).

o The National Institute on Aging estimates that Alzheimer disease costs this country $28 billion annually, in addition to the emotional costs to the family and others.

Between 10-20 percent (2-4 million) of those elderly living in the community have some degree of incontinence. The prevalence increases to between 40-50 percent in those elderly in nursing homes (600,000-700,000) (Office of Technology Assessment).

o The U.S. Surgeon General has estimated that the United States spends $8 billion a year on incontinence. Incontinence adds between $3-11 to the daily cost of caring for a nursing home patient.

15-20 million Americans are affected by osteoporosis and it is the underlying cause of about two-thirds of hip fractures in older people (Office of Technology Assessment).

o The total cost of osteoporosis in the United States has been estimated at $3.8 billion annually (Office of Technology Assessment).

Osteoarthritis is severe enough in 16-20 million Americans to cause symptoms. Osteoarthritis causing severe or moderate pain was noted in 6.6 percent of those 65 to 74 in the National Health and Nutritional Examination Survey.

o Osteoarthritis is a major factor in health care costs and patient morbidity, but is not a direct cause of death. The Arthritis Foundation estimated the total costs of all forms of arthritis at $13.3 billion in 1983, of which osteoarthritis accounted for approximately 70-70 percent (more than $7 billion).

Each year 1.3 million people, of whom one million are elderly, will spend time in nursing homes. For each older person in a nursing home, there is one at home with equal disability (National Institute on Aging).

o The Health Care Financing Administration estimates that the federal government spends over $20 billion dollars a year in nursing home costs. Alzheimer disease, incontinence, and osteoporosis are among the leading reasons for nursing home admissions.

In addition to the costs of chronic illness in terms of hospital care, long-term care, and rehabilitation, the social cost to the individual and his or her family, which is substantial although difficult to measure, must also be considered.

Growing Implications of Health Care

The figures presented represent the current incidence and cost. As the population of this nation ages, we can only expect these diseases, absent discoveries of ways to prevent or cure them, to become more prevalent. By 1990, the nursing home population aged 65 years and older is expected to reach nearly 1.7 million, and annual nursing home costs, the fastest growing segment of health care expenditures, are projected to increase to $76 billion (*The Need for Long-Term Care: Information and Issues*, Federal Council on Aging). By the middle of the next century, the nursing home population is expected to reach 5.4 million (*Aging America*. U.S. Senate Select Committee on Aging).

As the elderly population and its demand for services expand, so does the need for persons with knowledge and skills in planning and delivering services to the elderly and for trained researchers and scientists to discover more effective and efficient ways to deliver services and to devise improved methods of prevention and care for the aging and aged. Discovering how, why, and under what circumstances age-related declines may be prevented, reversed, or ameliorated could have a significant impact on lowering costs of health care and dependency and adding to the quality of life of the older person and his/her family.

All Generations Benefit From Research on Aging

While current cohorts of the elderly sometimes benefit directly from research, direct and indirect benefits also accrue to persons of all ages. For example, indirect benefits of research on aging may include decreased health care costs to taxpayers and reduced caregiving costs--financial, emotional, and physical--to families who provide support to older relatives.

Further, the actual benefits of most research on aging very often accrue to those who are not old. For instance, research on osteoporosis, a condition particularly noticeable among postmenopausal women, has resulted in a prescription for preventive maintenance involving diet exercise to develop and maintain bone mass, and other life-style factors for women of all ages (Office of Technology Assessment). Alzheimer disease research, while searching for a cure, treatment and prevention interventions, also may provide new understandings about Down's syndrome and Parkinson's disease. Furthermore, it should be noted that a number of the chronic diseases discussed, although particularly prevalent among older persons, also affect significant numbers of non-elderly persons.

Indeed, research focused on a particular concern of an aging society may benefit only _future_ cohorts of the elderly. But although today's elderly and perhaps even today's middle-aged _may never benefit personally_ from some of this research, the knowledge that flows from their investments in research will be transferred as a legacy to future generations in society. In a very fundamental way, then, research on aging is an intergenerational transfer of great benefit to persons of all ages as well as to those yet to be born. It is an investment in our common future.

FY 1988 Administration Proposal and Its Impact

According to an Office of Technology report (_Technology and Aging in America_, 1985), federal support for biomedical research has remained fairly constant in real dollars over the past decade, but has declined as a proportion of health care costs from 3.9 percent in 1972 to 2.9 percent in 1982. Funding for biomedical research also has failed to keep pace with overall trends and research in development: the proportion of dollars going to biomedical vs. other types of research declined from 12.4 percent in 1972 to 11.7 percent in 1982.

The Administration's FY 1988 budget proposal calls for cutting back the National Institute on Aging's budget from $177 million in FY 1987 to $166 million in FY 1988. The Administration's figures for FY 1988 assume the extended availability of funds from FY 1987 to FY 1988. These figures, therefore, mask the real impact of the Administration's proposals. If Congress were to disallow the extended availability of the FY 1987 funds, as the Gerontological Society thinks it should, the funds available to NIA in FY 1988 would drop to $156 million, an 11 percent reduction. This would mean that the new research project grants would be cut in third, dropping from 199 in FY 1987 to 78 in FY 1988. In addition, a cut of this magnitude would necessitate approximately a 18.5 percent downward negotiation rate for both competing and noncompeting awards. The Administration's proposed reductions in NIA's appropriation comes at a time when a number of new and promising discoveries about Alzheimer disease are being made. Two items recently in the news include the possibility of THA as a drug for treatment of Alzheimer disease and the finding of what may be a genetic marker for Alzheimer disease.

A clinical trial to test the effectiveness of the THA drug is scheduled to begin this year. Ten NIA-supported Alzheimer Disease Research Centers are already in place and ready to begin the trails, cutting the costs and reducing the "normal" start-up time by at least a year and a half. If the Administration's budget is adopted, NIA would be forced to pull money from other programs to pay for the clinical trials.

Another area that would be adversely affected by the Administration's FY 1988 proposal is education and training activities. A report published by the Department of Health and Human Services (DHHS) in 1984 clearly documents the growing need for health and allied health professionals and the serious lack of education and training efforts being undertaken to address those needs. Faculty and investigators with special training in gerontology are in short supply, states the report, with estimates ranging from 5-25 percent of the number required in various fields. The report also estimates that a total of 2,000-2,600 physicians and other academic investigators will be needed by the year 2000. If NIA's training programs continue at their same levels, we can expect a shortfall of about one-half the projected need in the year 2000.

The Administration's proposals totally disregard the concerns raised and recommendations made in the DHHS report, calling instead for a

reduction in the number of research career awards from 87 (FY 1987) to 78 (FY 1988) and in the number of full-time training positions from 269 (FY 1987) to 249 (FY 1988).

Perhaps the most serious impact of the Administration's proposal would be the reduction in NIA personnel. In 1984, the National Institute on Aging reported a total of 378 full-time equivalent positions. This figure has dropped steadily over the past few years and is shown at 343 in the FY 1988 Administration budget. The impact of reduced personnel is already being felt. There are fewer NIA staff to handle a larger grant load due to special initiatives such as the Alzheimer centers and the teaching nursing homes.

The reduction in staff also has affected the start-up of several new programs. For example, the phase-in time for the Laboratory of Molecular Genetics has been slower than anticipated due to lack of personnel. A newly established neurosciences program, a rapidly growing area, also has experienced a slowed start-up phase. NIA has had to defer hiring a geneticist for its Molecular and Cellular Biology Branch. These are just a few examples.

Summary

The Gerontological Society has continued to stress in its testimony before Congress the importance of planning and meeting the challenges of an aging society. An investment today can mean tremendous payoffs in the future. For example, by the middle of the next century, the nursing home population is expected to reach 5.4 million (Aging America, U.S. Senate

Special Committee on Aging). If we can reduce the need for nursing home care by a mere 5 percent, conservative estimates indicate that nursing home expenditures would be reduced by over a million dollars **per day.**

Earlier in this testimony we outlined the costs associated with some of the major chronic diseases that are particularly prevalent among the elderly. If we do not make some progress in reducing or eliminating the incidence of these diseases, we can only expect health care expenses to continue to climb. Research, even more than the cost containment measures currently being proposed, has the potential for dramatically reducing our health care costs.

ITEM 8

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Chairperson of the Board

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STATEMENT BY

ASOCIACION NACIONAL PRO PERSONAS MAYORES
NATIONAL ASSOCIATION FOR THE HISPANIC ELDERLY)

AT A HEARING ON

PROPOSED FISCAL YEAR 1988 BUDGET: WHAT IT MEANS FOR OLDER AMERICAS

BEFORE THE

SENATE COMMITTEE ON AGING

MARCH 13, 1987

National Association For Hispanic Elderly
National Executive Offices: 2727 West Sixth Street, Suite 270, Los Angeles, CA 90057 (213) 487-1922

Senator Melcher and Members of the Senate Committee on Aging, the Asociacion Nacional Pro Personas Mayores (National Association for the Hispanic Elderly) welcomes the opportunity to submit testimony for your hearing concerning the impact of the Administration's fiscal year (FY) 1988 budget on older Americans. Our statement will focus largely on the effect of the budget proposals for aged and aging Hispanics.

At the outset, the Asociacion wishes to commend the Committee for holding this timely and important hearing. We also want to express our sincere best wishes to you, Senator Melcher, in your new capacity as chairman of the Senate Committee on Aging. The Asociacion looks forward to working with you and your staff.

A. Older Americans Act

The Asociacion is deeply concerned about the Administration's proposed $2.210-billion generic appropriation for nearly all social services activities within the Office of Human Development Services (OHDS), including the Older Americans Act, Head Start, and several other programs. The FY 1988 budget claims that the generic appropriation "is in no way a block grant consolidation proposal."

However, this measure certainly has the appearance of being a block grant. Even if the budget document is accurate, the recommendation can eventually pave the way for block granting a wide variety of diverse activities currently under the OHDS umbrella.

The Asociacion opposes this proposal because the older Americans Act will lose much of its identity and visibility under a generic appropriation. Programmatic activities will be blurred. There will be less accountability under the new arrangement.

The Asociacion strongly believes that the Older Americans Act should continue as a separate categorical program. The Congress opted for this approach in 1965 when it enacted the Older Americans Act. One of the key reasons for this decision was to focus increased public attention on the growing needs of our rapidly growing aging population. That decision was sound and sensible when Congress initially created the Older Americans Act. We believe that the rationale is equally powerful now, if not more so.

We are confident that the Congress will reject this proposal when it considers the Older Americans Act reauthorization legislation this year. We urge the support of the Senate Committee on Aging to insure that the Older Americans Act retains its separate status with high visibility.

Additionally, the Asociacion is disturbed by the proposal to reprogram $12.5 million of FY 1987 Older Americans Act Title IV training, research, and demonstrations program funding. The budget proposes to shift (1) $11.1 million to offset the cost of a supplemental request to pay for prior claims for foster care, and (2) $1.4 million to compensate for costs associated with the 1987 pay raise for OHDS employees and the new Federal Employees' Retirement System.

This proposal would do great damage to Title IV, which has already experienced sharp cutbacks in funding since this Administration came to office. It would produce hefty reductions for numerous activities, including career preparation training, research on daily problems confronting Older Americans, and demonstrations to improve services for aged Hispanics and other older minorities.

Title IV has paid handsome dividends, despite a comparatively small appropriation in relation to total funding for the entire Older Americans Act. Some of the most innovative and popular programs in the entire field of aging have evolved from Older Americans Act demonstrations. These include the nutrition program for the elderly, Foster Grandparents, and the Retired Senior Volunteer Program (RSVP).

For these reasons, the Asociacion urges the Congress to reject the recommendation to reprogram $12.5 million of fiscal year 1987 funding for the Title IV training, research and demonstration program.

B. Senior Community Service Employment Program

The Administration's budget requests $326 million for the Older Americans Act Title V Senior Community Service Employment Program (SCSEP), the same amount as the FY 1987 appropriation. Title V has been an extraordinarily effective program for aged Hispanics and other low-income older Americans. It has provided a dignified means for disadvantaged persons 55 years or older to help themselves while helping others in their communities at the same time.

It is our understanding that Congressman Biaggi plans to seek an additional $10 million for the SCSEP when the House acts on the FY 1987 Supplemental Appropriations Act. Congressman William H. Natcher, chairman of the House Labor-Health and Human Services Education Appropriations Subcommittee, told Congressman Biaggi in a colloquy last year that he would support additional funding in a supplemental appropriation if the Senate would agree.

We urge the Senate Committee on Aging to back a $10-million supplemental funding increase for Title V for FY 1987. If the Congress votes a $10-million hike for the SCSEP for FY 1987, we recommend that the FY 1988 appropriation be at least $336 million.

A funding increase would be helpful for older Americans because poverty is on the rise for persons 55 or older. In fact, the number of poor individuals 55 or older recently increased by 153,000, from 5,628,000 in 1984 to 5,781,000 in 1985. Many more older Americans have incomes hovering at or very close to the poverty line.

Employment, however, can be an important tool to enable low-income older Americans to move off the poverty rolls onto the payrolls. Title V has been an especially effective program for older Hispanics because 8.4 percent of all enrollees are Hispanics. Moreover, 35.0 percent of all participants are members of minority groups.

c. Medicare

The Asociacion is also opposed to budget proposals to increase out-of-pocket payments for elderly Medicare beneficiaries. These include measures to (1) raise the Part B Supplementary Medical Insurance premium so that it would finance 35 percent of the Part B program costs, rather than 25 percent as under law; (2) delay Medicare coverage until the first day of the month following the month in which age 65 is achieved; and (3) index the Part B deductible to the Medicare Economic Index.

These proposals will only saddle aged Hispanics and other older Americans with more out-of-pocket payments. The harsh reality is that the elderly now spend about 15 percent of their income on health care. In fact, out-of-pocket payments for health care for older Americans is basically the same as it was before Medicare became effective in 1966.

In 1984, annual out-of-pocket payments for persons 65 or older averaged $1,055, more than three times the amount ($310) spent by other age groups. If nursing home costs are considered, average out-of-pocket health care expenses for the aged amounted to $1,705.

The Asociacion believes that there are more effective ways to balance the budget than to force older Americans to shoulder an even larger burden of health care costs.

D. Social Security Administration

The Asociacion also recommends that the Senate Committee on Aging work to prevent further cuts in Social Security Administration staff, particularly at the local level. If proposed reductions go into effect, the Asociacion fears that service to the public will inevitably suffer.

The Social Security district office is one of the major front-line governmental units for aged Hispanics and other older Americans. For the most part, they have received good service. However, we hear alarming reports that ths quality of service in the Social Security district offices throughout our nation is declining. We are concerned that the situation may worsen if proposed staff reductions become effective. The number of full-time equivalent (FTE) positions at the Social Security Administration is projected to decline by nearly 3,700 this year, fron 75,494 in FY 1986 to 71,799 in FY 1987. The budget proposes to reduce the number of FTE positions to 69,345 during FY 1988. We call upon the Senate Committee on Aging to take the lead in rejecting these proposed staff reductions.

E. Conclusion

In conclusion, the Asociacion wishes to commend the Senate Committee on Aging for holding this hearing on the impact of the FY 1988 budget on older Americans. The Asociacion reaffirms its support for the proposals that we have discussed earlier in our statement. We believe that they are substantively sound and legislatively feasible. We sincerely hope to have the support of the Senate Committee on Aging for these measures.

Again, we express our desire to work with the Committee on Aging and its staff on the whole range of issues affecting Hispanic elderly and other older Americans during the 100th Congress.

ITEM 9

TESTIMONY

Prepared by:

NATIONAL ASSOCIATION OF NUTRITION
AND AGING SERVICES PROGRAMS
Ann Burgen, President
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Written Testimony
Prepared for:

UNITED STATES SENATE
Special Committee on Aging

March 18, 1987

Senator Melcher and members of the Senate Special Committee on Aging. The National Association of Nutrition and Aging Services Programs (NANASP) is pleased to have an opportunity to submit testimony for this important hearing on the fiscal year 1988 budget plan and its impact on aging programs.

NANASP is a membership organization representing direct service providers from every state. Our mission is to convey information from the field to decision makers in Washington about how various actions affect Older Americans Act programs and the elders of our country that this legislation was created to serve. Throughout the past six years we have worked successfully with our members to achieve efficiencies in our nutrition and other support service programs to ensure that the increase in service demand is addressed through increased delivery of services.

Our record, particularly in nutrition services, is one that we are proud of. Our members have a strong commitment to local services and this commitment leads them to constantly strive to improve their programs. As an Association, we have taken major steps this past year to assist them in meeting their goals of more cost effective services by initiating a grant with USDA to educate nutrition projects on creative utilization of commodity foods and developing a program allowing for cost savings through a national purchasing plan.

NANASP is eager to work with Congressional leaders to do all that we can to assure that older citizens receive the community based care they require. When asked to comment on the FY88 budget, we found it difficult to do because this year we do not have line items to review and compare against past appropriations or projected needs.

The problem is the "generic appropriation" request for Older Americans Act and 25 other human services programs proposed by the Administration. Not only must we deal with a significant loss of total funds to OHDS, but aging programs are also earmarked for shifts in monies in FY88. There are no guarantees in this budget that adequate levels of funding will be available for either Title IIIB or IIIC. If we could evaluate this budget, we could at least help Congress identify the gap between funded service levels and projected demand, but with this budgeting approach, even that basic step is impossible.

In addition to these very tangible problems with the FY88 budget, it is also alarming that various groups with equally serious need for government human service assistance will be competing for limited dollars in this budget arena. This can only lead to increased intergenerational conflict and dilute the importance of the legislation enacted to help these needy groups.

NANASP feels confident that Congressional leaders that have supported Older Americans Act legislation will recognize the serious implications of this 1988 Administration budget and act to ensure that these aging programs, as well as other human services programs, be presented independently for fair budget evaluations.

ITEM 10

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES
1533 NEW HAMPSHIRE AVE. N.W. WASHINGTON, D.C. 20036 AREA CODE (202) 234-0832

STATEMENT OF THE NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES
SUBMITTED TO THE SENATE SPECIAL COMMITTEE ON AGING
ON THE PROPOSED FISCAL YEAR 1988 BUDGET:
WHAT IT MEANS FOR OLDER AMERICANS

MARCH 11, 1987

The National Association of Retired Federal Employees (NARFE) appreciates the opportunity to present our comments on the effects of the Administration's proposed budget for Fiscal Year 1988 on one group of older Americans, the 2 million Civil Service retirees and survivors who our organization represents.

The Administration's plan for achieving savings in the new fiscal year recommends $2 billion in cuts from the Civil Service Retirement System (CSRS) and the Federal Employees Health Benefits Program (FEHBP), the two programs on which Civil Service annuitants and survivors are most dependent for retirement security. Two specific legislative changes proposed in next year's budget would prove most detrimental to federal annuitants and survivors:

- Inflation protection would be reduced by limiting all future CSRS cost-of-living adjustments to the percentage change in the Consumer Price Index minus 1 percent, unless the CPI falls below 3 percent, in which case the COLA would be the actual CPI increase or 2 percent, whichever is less.
- The FEHB Program would be restructured so that the government's share of premiums would be based on a weighted average of all plans in the program instead of using the average cost of the six largest FEHB

health insurance carriers. Because this change is proposed to reduce the employer government's cost of premiums, the restructuring formula will shift a greater cost burden onto the health insurance enrollees.

THE COLA PROPOSAL

While the media and many Members of Congress proclaim that the Administration's proposals were essentially "dead before arrival," Civil Service annuitants and survivors are acutely aware that their cost-of-living adjustments are still "on the table" as a budget savings.

An objective in federal retirement policies is that annuities should retain purchasing power over the span of retirement. Since inflation robs annuities of their value over time, the COLA is the only fair means of maintaining value to the annuities relative to a point on a standard measurement of price at the time the retiree became eligible for an annuity. Despite this propounded objective, Congress adopted the Gramm-Rudman-Hollings Amendment in December 1985 which included a provision placing Civil Service Retirement COLAs within the purview of sequestration, and thereby eliminated the 3.1% inflation adjustment that was to have been paid in the January 1986 annuity checks. Although Congress later amended Gramm-Rudman-Hollings to exempt future COLAs from automatic sequestration, purchasing power of our annuities had been lost never to be regained.

As Congressional deliberations regarding ways of meeting the FY 1988 deficit targets take place, it is conceivable that a less-than-full COLA for federal retirees could once again be seen as a viable area for budget savings. After all, it could be rationalized that if inflation remains low, then no real harm will be done if annuitants lose a small portion of their inflation adjustment, and if inflation is high then annuitants would be compensated for all but one percent of the rise in the Consumer Price Index. However, we contend that if the objective of COLAs is to provide retirees with formulated replacement incomes that do not lose value with increasing prices, then 100 percent indexing is required: Fixed income adjusted fully for inflation retains its purchasing power across variable price changes - any adjustment less than 100 percent of the CPI diminishes the real dollar value of earned annuities. Therefore, NARFE firmly adheres to the belief that any further erosion of annuities is unacceptable.

Despite the oft-touted proposition that the Civil Service Retirement System is over-generous, Civil Service annuitants received an average of $1,128 per month in 1986, and survivor annuitants received $536 per month on average. We contend that it is paultry public policy for the Administration or Congress to single out federal retirees as the only group of older Americans for whom inflation protection on their primary source of retirement income becomes controversial each year. This group of older Americans does not deserve to be placed in this position of insecurity regarding the value of their annuities year after year just because their employer or their deceased spouse's employer was the Federal government.

HEALTH INSURANCE PROPOSALS

Since it is obvious that the premium costs of the Federal Employees Health Benefits programs will not be going down, any savings recognized by the Federal government as employer will result in enrollees bearing a larger percentage share of ever-increasing costs.

Civil Service annuitants, like all other older Americans, are deeply concerned with having adequate means to cover the health care needs they may have later in life. And like other older Americans, annuitants are faced with the possibility that the combination of public programs such as Medicare and private insurance such as FEHB programs and Medigap insurance programs may not provide the health care coverage they may ultimately require.

No doubt, Civil Service annuitants will sacrifice to pay the increased cost of health insurance. Increased publicity surrounding Congressional and Administration interest in catastrophic care coverage and long-term care have heightened the American public's concern regarding the financial devastation that can occur when a family member requires hospitalization for a serious illness or needs long-term care. For the most part, Federal retirees covered by FEHB plans are protected from the catastrophy of acute illness. But, the Federal retiree and survivor shares the plight of the vast majority of Americans with regard to insurance protection for nursing home or home health care costs associated with chronic, long-term illness. Therefore, NARFE believes that any increased premium cost-sharing imposed on Federal employees and retirees should be accompanied by improved benefits and coverage which address the long-term care needs of annuitants and their families.

Finally, we would like to emphasize that NARFE shares the goal of other organizations representing older Americans that health and social service programs for the elderly and the income security provisions that provide dignity and sustenance for older citizens be preserved throughout the budget process. While the objectives of these programs remain as valid as when first enacted, benefit cuts and other reductions over the last few years have forced a narrowing of the visions upon which these programs were founded. It is our hope that the integrity with which these programs are handled as Congress wrestles with the budget deficit serves to restore a sense of security to older persons who stand to lose so much.

We thank you for the opportunity to submit this testimony to the Special Committee and for your interest in our issues.

ITEM 11

NASW

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Testimony Before the Special Committee on Aging of the United States Senate

on

The FY 1988 Budget and Older Americans

Submitted by:

National Association of
Social Workers

March 13, 1987

The National Association of Social Workers (NASW), on behalf of its 100,000 members, is pleased to have this opportunity to present its views on the FY 1988 budget as it relates to older Americans.

The social work profession has long been committed to improving the quality of life for our nation's elderly. Social workers are found in hospital settings, long-term care facilities, home health agencies, social service agencies, senior centers, and community-based organizations. They provide adult protective and emergency services, mental health services, respite care, day care, advocacy, case management, medical social services, information and referral, family support services, recreation, socialization, and community education. They are the link between the elderly and essential community resources -- and they are often instrumental in alleviating problems and facilitating positive functioning, thereby helping to prevent institutionalization.

It is on the basis of the collective experience of its members that NASW offers the following observations on the FY 1988 budget and older Americans.

The Administration's budget, overall, seems to reflect the unfortunate prevailing notion that elderly Americans are no longer needy. In 1977, NASW adopted a formal policy on aging, which detailed the needs of the elderly and delineated the goals of economic security; elimination of age discrimination in employment and retirement; adequate health care; access to mental health services; long-term care; barrier-free transportation; affordable housing; social services; and sensitivity to the special needs of the rural and minority elderly populations. While the economic position of older Americans has indeed improved, they remain a vulnerable population in need of precisely those services outlined above. Our goals for the elderly have not yet been met.

The Administration's FY 1988 budget, like its budgets throughout the Reagan years, disproportionately burdens domestic social programs in order to fund the military buildup. Since the passage of Gramm-Rudman in 1985, the Administration has committed itself to reducing the deficit, without reducing Pentagon spending or raising taxes. Savings, then, can be achieved only through repeated cuts in already decimated domestic social programs. As the availability of resources continues to decrease, needy constituencies will increasingly be forced to compete for what remains. There is no guarantee that the elderly will be the victors.

There are many reductions contemplated by the Administration's budget which would have a profound effect on the health and well-being of older Americans. In fact, programs benefiting the elderly were singled out for some of the largest cuts overall. These include the following:

Medicare: Using the Congressional Budget Office's baseline data, the President's proposal would reduce outlays for Medicare by $5.1 billion in 1988 and $52.7 billion by 1992. This accounts for a full one-sixth of all proposed reductions in non-defense spending. Nearly 20 percent of the anticipated out-of-pocket savings would come from increased costs to beneficiaries. Specifically, the Part B premium for new beneficiaries would be increased by more than one-third; the Medicare deductible would automatically increase each year; and initial eligibility for Medicare coverage would be delayed by one month. In light of the fact that many elderly persons live just above the poverty line -- and that nearly half of all elderly persons live below twice the poverty line -- these increases in beneficiary costs could be devastating.

Medicaid: Cuts in Medicaid, early in the Reagan Administration, left an estimated 35 million Americans without health insurance coverage. As of 1984, there were 3.3 million elderly Americans living below the poverty line. The Administration has again proposed cuts in the Medicaid program, totaling $1.3 billion in 1988 and $21.6 billion over five years. Federal Medicaid payments to states would be capped at $1 billion below current spending, with a limit on future payments which reflects only the increase in the medical services component of the Consumer Price Index. The President also proposes to further restrict Medicaid coverage of people in public institutions. These changes would severely curtail states' ability to provide health care to the poor; particularly at-risk would be elderly poor persons in need of long-term nursing home care.

Housing: The Administration has proposed severe reductions in housing assistance, totaling $300 million in 1988 and $8.5 billion over five years. The President requested only $5.3 billion to support low-income rental assistance programs -- over $4 billion less than the FY 1987 level. Vouchers would be used to provide most additional assistance, requiring the elderly, handicapped, and poor to find their own housing in the private market; we believe that existing shortages of low-cost housing would render this plan untenable for those in need. Lastly, Section 202 housing for the elderly and disabled would be severely limited, as would public housing subsidies. Since more than one-third of America's elderly live alone or with non-relatives, these cuts in funding would inevitably result in more elderly persons becoming homeless, living in sub-standard housing, or depleting limited resources for housing at the expense of other pressing needs.

Energy Assistance: The Low-Income Home Energy Assistance Program (LIHEAP), which helps pay utility bills for the poor and prevent utility cutoffs, would be reduced by more than one-third under the Reagan budget. This would be in addition to cuts already made in FY 1987, which left the program able to serve only about one-third of eligible households. These reductions particularly affect the low-income elderly who have little earning potential, and are often rendered vulnerable by illness or impaired mobility.

Food Stamps: Under the Administration's budget, the food stamp program would be cut by $300 million in 1988 and $1.3 billion by 1992. These savings would be achieved by increasing sanctions against states with high error rates and by reducing food stamp benefits for persons who receive energy assistance, many of whom are elderly.

NASW believes that, in addition to programs which exclusively benefit the low-income elderly, social service programs which benefit all elderly persons must be retained at adequate funding levels. Earlier reductions and freezes in funding have resulted in severe service reductions in many such programs, leading inexorably toward decreased self-sufficiency for the elderly and increased institutionalization.

The Title XX Social Services Block Grant: Title XX of the Social Security Act was created in 1974 as an entitlement for states to make available the full complement of social services for persons of all ages. As part of the Omnibus Budget Reconciliation Act of 1981, Title XX was converted to a block grant and its funding was cut by 20 percent. Since that time, funding has been restored in small amounts, but is still lower than it was before the program was block-granted. Since 1984, Title XX has remained at its authorization ceiling of $2.7 billion; between reductions and inflation, this is more than a 50 percent reduction, in real terms, from its level ten years ago.

The Administration's budget again proposes no increase for Title XX. Meanwhile, states have been increasingly unable to provide those essential services for which Title XX was intended. Ten to 20 percent of the funds are used to aid older adults, through the provision of chore, homemaker, and in-home personal care services; adult day care; adult protective and emergency services; case management; employment; transportation; housing and legal services; counseling; recreation; and information and referral. Many of these services are coordinated with Medicare and Medicaid; all are designed to prevent premature institutionalization.

Reductions in federal Title XX funds have forced many states to reduce or eliminate various services to the elderly. The 20 percent reduction between 1981 and 1982 alone caused spending on in-home care, in a sample state, to plummet from $1.4 million to only $100,000. Caseloads, in that same state, jumped from 169 persons per month to only 26, over the same one-year period. Many states have resisted eliminating services and have tried to compensate for diminishing federal dollars. In one such state, despite all efforts, in-home visits to the elderly dropped by 24 percent between 1981 and 1983; adult protective services suffered a 26 percent reduction in staff; and the number of persons receiving protective services was reduced by 29 percent. As an alternative to service reductions, some states have begun to charge fees for services, jeopardizing access for low-income elderly persons. There is no question that reduced federal funds result in significant cuts at the state level. Under the President's budget, the crisis in social services for older Americans will continue.

The situation is further exacerbated by attempts, in the Reagan budget, to cut other programs with the expectation that Title XX will pick up the slack. In justifying the proposed elimination of the Legal Services Corporation, the Office of Management and Budget (OMB) stated, "adequate state funds are available to fund legal aid through the social services block grant, currently funded at $2.7 billion." Likewise, in justifying its phase-out of the Community Services Block Grant, OMB stated, "Effective community action agencies can be funded through the social services block grant . . ." With funding for Title XX already grossly inadequate, these program eliminations will add to the competition for scarce resources, enabling Title XX to meet fewer and fewer pressing needs.

Older Americans Act: The Older Americans Act provides congregate and home-delivered meals, nutrition education, adult day care, transportation, community and legal services, and employment services. It also provides grants for senior centers, for training in the field of aging, and for demonstration projects.

The President's budget proposes reducing the research component of the Older Americans Act by 50 percent, and maintaining funding for other services under the Act at FY 1987 levels.

Like Title XX, the Older Americans Act has suffered a decline in real dollars because of its failure to keep pace with inflation. Current levels of service to the elderly cannot be maintained without an increase.

Generic Appropriation: The President's budget proposes a "generic appropriation" of $2.2 billion to cover all twenty-six discretionary social service programs administered by the Office of Human Development Services in HHS. These include numerous programs for the aging (supportive services and centers; congregate meals; home-delivered meals; research, training, and discretionary projects; etc.), in addition to child welfare, developmental disabilities, and Native American programs.

Although the Administration is quick to disavow any suggestion that the "generic appropriation" is a block grant in disguise, there are some striking similarities -- notably a sizable cut in funding as part of the consolidation plan. In this case, the cut totals $34 million (or $54 million, if Head Start is given its recommended $20 million increase). This cut, like others discussed earlier, cannot help but reduce service quality and/or availability. Furthermore, the "generic appropriation" would essentially shift discretion from

Congress to the Department of Health and Human Services as to how funds are to be allocated among the various programs. It is unclear what mechanisms the Administration would put in place to ensure that funds are appropriately targeted and that competing needs and interests are adequately met.

Although the elderly are a heterogeneous population with a wide range of assets and capabilities, as a group they are disproportionately vulnerable to income deficiency, chronic illness, functional disabilities, housing deficiencies, crime, isolation and depression. Services which prevent or alleviate these phenomena must be adequately funded, so that the human and financial costs associated with dependence and institutionalization can be avoided.

The Administration's FY 1988 budget, like earlier budgets of the Reagan years, moves us further away from this goal. It proposes reductions in funding which would have far-reaching effects on the health and well-being of older Americans.

Thank you again for this opportunity to share our views.

ITEM 12

POINT OF VIEW

A PUBLICATION OF THE CONGRESSIONAL BLACK CAUCUS FOUNDATION

WINTER 1987

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Mike Espy ● Floyd Flake ● Kweisi Mfume ● John Lewis

THE BLACK ELDERLY:

A Forgotten Statistic

By Samuel J. Simmons

Older Blacks are at or near the bottom rung of the aging ladder by virtually any standard one would choose to use: income, health, housing, and overall quality of life. This fundamental fact paved the way in 1970 for the creation of the National Caucus and Center on Black Aged.

Today, NCBA serves as the only national organization that is devoted exclusively to improving the quality of life for older Blacks. For the past 16 years, NCBA has pursued a twofold strategy to help aged and aging Blacks. First, NCBA has either provided direct services to older Blacks or has encouraged others — such as churches, fraternal organizations, and labor unions — to do their part in responding to the service needs of elderly Blacks. Second, NCBA has attempted to be a forceful and effective advocate on behalf of older Blacks before Congress and administrative agencies.

NCBA's major advocacy effort in 1986 was the sponsorship of a series of forums throughout our nation to improve public understanding about the true state of affairs for older Blacks in America. Unfortunately, the American public has developed an "ostrich mentality" when the plight of the Black elderly is mentioned. The problems now facing older Blacks, however, will not miraculously vanish by a "head-in-the-sand" approach. Our nation must be honest and forthright in developing a well conceived and comprehensive action plan to help more older Blacks live in dignity and self respect.

The harsh reality is that older Americans have the highest poverty rate among adults. Only young people and children — those individuals aged 21 and younger — have a higher poverty rate than persons 65 or older.

Aged Blacks are the poorest of the poor among the elderly. No other major aged racial or ethnic group has a higher poverty rate than older Blacks — not aged Hispanics, not elderly Indians, not older Asians, and not any other group.

This is a key reason that NCBA and the House Committee on Aging undertook a cooperative project during the past year to set the record straight about the status of older Blacks in the United States. NCBA held six issue forums on major concerns and challenges for aged Blacks: income, employment, health, crime, services, and the budget. In addition, the House Committee on Aging conducted three hearings in Detroit, Memphis, and Washington, D.C. Eleven members of the Congressional Black Caucus (CBC) and several members from the House Committee on Aging actively participated in the nine forums and hearings in eight major cities throughout the U.S. More than 100 senior citizens and other experts testified.

This project, which was a year in the making, has produced the first comprehensive snapshot of aged Blacks. Equally important, the forums and hearings have helped to raise public awareness about the plight of elderly Blacks.

Rep. George Crockett receives an award from NCBA President Simmons.

MAJOR FINDINGS

Many people know in a general way that the quality of life for older Blacks is significantly lower than other groups in our society. But, they are often surprised – sometimes shocked – by the degree of deprivation among aged Blacks.

Income

The forums and hearings reaffirmed that a retirement income crisis already affects more than one million Blacks 65 years or older and threatens to engulf others. Many senior citizens did not become poor until they became old. But, this is simply not true for a large proportion of aged Blacks. They have known poverty all their lives — from the moment of conception until death. Advancing age simply intensifies their problems.

To a very large degree, older Blacks are treading water in a swirling economic rapids that threatens to drown them. More than 700,000 live in abject poverty. They are living on less than $5,156 a year ($6,503 for an aged couple). You do not need to be a Harvard economist to know that it is difficult to eke out an existence when you must pay for housing, food, medical care, transportation, clothing, and other necessities with just $99 a week ($125 for an elderly couple) or less, and quite often substantially less for aged Blacks.

These figures, depressing as they are, represent only one dimension of a bleak economic picture for older Blacks. The harsh reality is that aged Blacks are three times as likely to be poor as elderly whites. In 1985, 31.5 percent of all Blacks 65 or older lived in poverty, compared to 11.0 percent for aged Whites.

This is just the tip of the iceberg. Another 900,000 elderly Blacks are economically vulnerable. Their incomes do not exceed twice the poverty thresholds: about $10,300 for an older individual and approximately $13,000 for an aged couple. The net impact is that seven out of ten older Blacks are either poor or economically vulnerable.

The situation is even worse for elderly Black women, especially those who live alone or with nonrelatives. About seven out of eight (87.9 percent) are either poor or economically vulnerable.

Health Care

The plight of the Black aged is manifested in many ways. Economic deprivation is one noteworthy illustration. Another striking example is the shorter life expectancy for Blacks than Whites. **In fact, life expectancy is 6.6 years longer for White males than Black males: 71.5 years versus 64.9 years. White females can expect to live, on the average 5.3 years longer than Black females: 78.8 years compared to 73.5 years.**

More than one-half (55 percent) of all Blacks 65 or older consider their health to be poor or just fair, in contrast to one-third (33 percent) among aged Whites. Aged Blacks have emphasized that they have been victimized by our two-tier health system. They often receive "welfare medicine," while the more affluent or those with decent company health insurance plans receive quality care.

This point was made powerfully at a House Committee on Aging hearing chaired by *Congressman George W. Crockett, Jr. (D-MI)* in Detroit. Elderly witnesses also spoke in moving terms about the adverse effect of the diagnostically related group (DRG) system. They generally agreed that the DRG mechanism was causing patients to be discharged "quicker and sicker" from hospitals.

Housing

Housing is the number one expenditure for the elderly. Many older Americans spend at least one-third of their income for housing. A significant percentage spend substantially more, particularly older Blacks.

Housing is perhaps the most visible sign of deprivation among aged Blacks, whether they live in urban ghettos or rural slums. Elderly Blacks, for example, are 3½ times as likely as older Whites to be without plumbing for their exclusive use. About three out of seven (43.5 percent) houses occupied by aged Blacks lack central heating.

Today numerous older Blacks find themselves in an impossible housing situation. Their homes may be old and dilapidated, but their meager incomes make it impossible for them to move to more suitable housing or to repair their existing homes.

These problems have been intensified by sharp funding cutbacks for federallyassisted housing in recent years. Former Housing and Urban Development Secretary Robert Weaver estimates that one out of every four American households cannot obtain adequate housing at a price within their reach. He added, "Low-income senior citizens are among the groups most adversely affected, especially Black low-income senior citizens."

"Elderly Black Americans rely most heavily upon Social Security benefits as the sole or principal source of household income."

Crime

The fear of vicitimization is especially acute among older Blacks. This point was made emphatically by aged Black victims who testified at a hearing conducted by *Congressman Charles A. Hayes (D-IL)* in Chicago. One important reason is that criminals find older Americans to be tempting prey because they are generally slower moving and less able to resist an attack than younger persons.

An elderly witness told CBC Members:

> "...I have four locks on my front door, four locks on my back door, gates to the front, gates to the back, gates to the windows. Now when I go in my apartment I have all of this to unlock. Then when I shut the door, it sounds like I've shut myself in prison."

Widespread fear, apathy, and powerlessness exist among aged Blacks and other older Americans who live in high crime areas. In far too many cases, they attempt to retreat to the sanctuaries of their own homes. But, they frequently find that their own homes are not secure from burglars, vandals or other assailants. The Chicago hearing reaffirmed forcefully that the fear of crime has a chilling impact on the lives of older Blacks.

"Older Blacks... remain poorer, less employed, less educated, less healthy, and less able to provide for themselves."

Services

Aged Blacks and other elderly minorities continue to be underrepresented in Older Americans Act and other service programs. Yet, their need for a wide range of supportive services is often 2 to 3½ times as great as for older Whites.

'Because funds for housing programs are committed but not actually spent until late years, the true effects of reduction in federal support for housing assistance as reflected in budget authority will not be realized for several years. The conclusion to be drawn from this is that the housing crisis will get worse for lower-income families, especially Black elderly."

These points were emphatically made at the NCBA forum in Los Angeles, which *Representatives Augustus F. Hawkins (D-CA), Julian C. Dixon (D-CA), and Mervyn M. Dymally (D-CA)* conducted jointly. A 1982 Civil Rights Commission report, as well as earlier equity studies funded by the Administration on Aging, have all reached an identical conclusion.

However, minority participation in the Older Americans Act supportive and nutrition services programs continues to drop. In fact, the minority participation rate for the Title III-B supportive services program has plummeted by one-fourth (24.7 percent), from 21.9 percent in fiscal year 1980 to 16.5 percent in 1985. This rate represents an all time low for this decade.

"Sources of income during retirement years for elderly Blacks are few and inadequate for their level of need."

Older Blacks have been especially hard hit. Nearly 300,000 fewer Blacks received Title III-B supportive services in 1985 than in 1980. During this decade, the aged Black participation rate has dropped by one-fourth (23.0 percent), from 13.9 percent in 1980 to 10.7 percent in 1985.

A similar pattern exists for elderly Blacks and other older minorities for the Title III-C nutrition program, although the decline has not been quite as severe as for supportive services.

NCBA Report and Recommendations

NCBA will soon publish a wrap-up report, summarizing the major findings at the nine forums and hearings conducted throughout our nation during the past year. In addition, the report will include a blueprint for a long awaited national policy to improve

"...older Black women constitute 19.5% of all aged women living in poverty. This is a rate twice that of white older women, and 1.25 times greater than the poverty rate for all American women."

living conditions for elderly Blacks.

NCBA is now developing recommendations to implement this action plan. But, none will be more important than a proposal developed by the Villers Foundation to abolish poverty completely for the elderly.

Currently, the maximum federal Supplemental Security Income (SSI) payment for an aged individual is $336 a month ($340 in 1987), which translates to $4,032 ($4,080 in 1987) on an annual basis. This is 77 percent of the 1986 projected poverty guideline ($5,240) for an elderly single person. The maximum federal SSI payment for an older couple is $504 a month ($6,048 a year). This is 92 percent of the estimated 1986 official poverty line ($6,600) for an aged couple. The 1987 federal SSI maximum payment will be $510 a month ($6,120 a year).

States can also supplement the federal SSI payments. However, only 26 states and the District of Columbia do so. The median state supplemental payment is $36 per month. In only four states — Alaska, California, Connecticut, and Massachusetts — the combined federal SSI payment and the state supplement exceed the official poverty line.

Based upon the fundamental premise that:

a. Poverty can only be abolished in the current political world if the recommendation is revenue neutral, and
b. It is not legislatively feasible in today's political climate to fund this proposal from the military budget, even though this objective is sound, worthy, and desirable.

The Villars Foundation proposes that:

1. The SSI income standards be raised to a level that would eliminate poverty for aged Blacks and other older Americans.
2. This measure be financed with general revenues from the present taxation of Social Security benefits from about 10 percent of all Social Security beneficiaries.
3. Those revenues be replaced with

RETIREMENT SECURITY – A PRIORITY FOR ELDERLY BLACKS

Achieving the goal of retirement income security is presently difficult for many older Black Americans and may continue to elude succeeding generations. Retirement income security (the financial ability to adequately maintain yourself and your dependents through payments from Social Security, private pensions, employment, or a combination of these) is directly related to the amount of money one has earned before retirement.

Thus, the lower income of Blacks in retirement is a direct result of the lower educational and vocational patterns of Blacks prior to retirement. The lower earning, for example, of Black males reflects the less diverse and lower earning capacity of Black males at every age. The median income level for Black males aged seventy or over was about $3,260.00. Elderly Blacks are only one-third as likely as their white counterparts to have income from assets (such as dividends, interest or rent) and only half as likely to be the recipients of a pension. Therefore, many of the Black elderly have little more to live on than payments from Social Security, SSI, public assistance, and unemployment and workers' compensation. These sources combine to account for 75% of all income for elderly Blacks in contrast to 50% for elderly whites.

This same disparity in retirement security is reflected in pension vesting, achieving a legal right to a benefit under a pension plan. For example, among civilian workers participating in private pension plans, 49% of whites vested in some form of pension benefit, as contrasted with only 41% of Blacks and 35% of Hispanics. Of those workers age 45 and older, 66% of whites were vested, in contrast to 58% of Blacks and 44% of Hispanics.

There are several legislative initiatives that may aid future Black retirees. Recent changes in federal pension law under the Tax Reduction Act of 1986 (TRAC) which will lower the required period of vesting to five years will greatly enhance the opportunity for Blacks and other minorities to ultimately receive a pension benefit in retirement. Legislation which would prevent the premature termination of so-called "overfunded" penion plans, H.R. 2701, introduced by Chairman Ed Roybal (D-CA) of the House Aging Committee, should be enacted by the Congress to better assure that benefits promised will ultimately be paid under a pension plan. Finally, strict enforcement of our present race and age discrimination statutes will better assure that all minorities will achieve gainful employment and the collateral benefits of private retirement and health benefits through such employment.

It is imperative that more attention and thought be devoted to better ensuring the retirement income security of a growing Black elderly population. Through greater exposure and education, through employment and through participation in the political process, Blacks and other minorities can and should enhance their own health and retirement security.

Roger J. Thomas
General Counsel
Select Committee on Aging
U.S. House of Representatives

additional payroll taxes from raising the Social Security maximum wage base for only about 7 percent of the most affluent workers covered under Social Security.

4. Payroll tax relief be provided for lower and moderate wage earners by exempting a portion of their earnings from the Social Security payroll tax. This would be especially beneficial for younger Black workers.

Conclusion

In conclusion, NCBA has made a long-range commitment to work for the abolition of poverty for aged Blacks and other older Americans. NCBA chapters throughout the nation will devote their full resources and attention to implement this goal.

NCBA's Board of Directors is also calling upon all Black institutions and organizations to endorse NCBA's action plan to eliminate poverty for the elderly.

This proposal can be a "win-win" situation for older Blacks, as well as younger Black workers. It is a legislatively attainable goal if NCBA, other national aging organizations, and national Black institutions join forces. We sincerely believe that all Blacks — whether they are young or old — will be victorious if NCBA, national aging organizations and other Black organizations work together to implement this proposal to abolish poverty.

CBC members who participated in the NCBA forums include **Representatives John Conyers, Jr. (D-MI), George W. Crockett, Jr. (D-MI), Julian C. Dixon (D-CA), Mervyn M. Dymally (D-CA), Harold E. Ford (D-TN), William H. Gray (D-PA), Augustus F. Hawkins (D-CA), Charles A. Hayes (D-IL), Major R. Owens (D-NY), Charles B. Rangel (D-NY), and Edolphus Towns (D-NY).**

Caucus members Conyers, Hayes, and Crockett with President Simmons at Chicago NCBA hearing

- NCBA, created in 1970, is a membership-based organization with 35 local chapters and 10 field offices located throughout the nation. The organization serves as a national advocate and provides employment, training, and housing services for the Black elderly.
- Samuel J. Simmons has served as president and CEO since 1982. He has previously served as an Assistant Secretary of HUD and is a member of the Board of Directors of the Federal National Mortgage Association.

National Caucus and Center on Black Aged, 1424 K Street, N.W., Washington, D.C. (202) 387-4022

ITEM 13

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

1300 19th Street, N.W., Suite 501, Washington, D.C. 20036 (202) 822-9459

STATEMENT OF

JAMES ROOSEVELT

CHAIRMAN OF
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

PRESENTED TO

THE SENATE SPECIAL COMMITTEE ON AGING

HEARING ON

THE ADMINISTRATION BUDGET

MARCH 13, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members. The vast majority of our members are Social Security recipients. For the most part these seniors also depend on Medicare as their primary health insurance protection. There is a serious concern among our members and older Americans generally about the erosion of programs which were intended to provide security in later years.

Frankly, the Administration's budget proposal for fiscal year 1988 disappoints me. The President's proposal to reduce Medicare and Medicaid spending by $60 billion over the next five years is unconscionable. Rather than strengthening health care coverage, a reduction of this magnitude will further eat away at our health care programs and foster the growing feeling of insecurity.

We are pleased that the President finally decided to adopt the catastrophic health plan developed by his Secretary of Health and Human Services, Dr. Bowen. Without question, it is an important beginning, but the President's budget sends a conflicting message. On the one hand, the President acknowledges seniors' need for protection against acute catastrophic illness, and on the other hand, he squeezes back on funding for Medicaid and the Older Americans Act which serve the long-term care needs of seniors.

In response to the Administration budget proposal, I want to focus on three issues of concern to our membership. They are: 1) increased Medicare out-of-pocket expenditures, 2) the impact of staff reductions on service to Social Security beneficiaries, and 3) the need for more money for the Older Americans Act.

MEDICARE OUT-OF-POCKET COSTS

Part B Premium and Deductible. The Administration proposes to index the Part B deductible because "the deductible will serve as an effective deterrent to unnecessary utilization." The Administration is shortsighted by failing to see that higher deductibles also discourage necessary care.

I do not believe that we need to further deter utilization of medical services. On the contrary, our health care system should facilitate older Americans in seeking necessary help earlier rather than later in a spell of illness. If early treatment is not sought, the condition can quickly deteriorate and eventually take a much higher physical and financial toll.

Furthermore, the Administration is proposing to increase the monthly premium for new beneficiaries from 25 to 35 percent of program cost, a 40 percent increase. The Administration's real goal is to increase Medicare premiums for all beneficiaries by the same 40 percent. This is the first year since 1983 it has not proposed the same premium increase for all beneficiaries. Increasing premiums for new beneficiaries only would discriminate against them and weaken senior citizen opposition to the premium increase. The National Committee opposes increased premiums for any and all beneficaries and, in fact, advocates reductions in future premiums.

It is estimated that senior citizens out-of-pocket medical expenses will increase as a percent of income from 16 to 18.5 percent by 1991. Increases in Part B premiums will be a major factor in out-of-pocket health care costs outstripping seniors' incomes. In fiscal year 1987, Part B premiums rose 15 percent over the previous year even though the overall cost-of-living increased only 1.3 percent. The government projects another 25 percent increase in the Part B premium in fiscal year 1988 from $17.90 to $22.30 a month. For a great many beneficiaries, $4.40 more a month will be a significant hardship.

The increases are part of the unchecked inflation in physician services and a shift of health care from Part A hospital care to Part B outpatient care as a result of the hospital cost containment program. Beneficiaries should not be responsible for inflation over which they have no control and Congress never intended for beneficiaries to suffer financially from the hospital cost containment program. Congress should solve the problem by returning to the formula it used in the late seventies which limited the increase in the Part B premium to no more than the COLA percentage.

Part A Deductible. Increases in the Medicare Part A hospital deductible must also be curbed once and for all. First, allow me to commend you, Mr. Chairman, and the other Members of Congress for your successful efforts to keep the increase of Medicare Part A hospital deductible at the $520 level for 1987. If it had not been for your efforts, the deductible would have risen to $572. Congress also set a new formula for calculating the deductible. However, while the new formula for increases is inherently more reasonable than the old method, the $520 base is unreasonable. Since 1981, the Part A deductible has risen 155 percent from $204 to $520. I think you will agree, that for the average worker living on a Social Security income of less than $500 per month, a $520 hospital deductible can be catastrophic. Needless to say, this problem is multiplied when a person is unfortunate enough to experience two or more hospitalizations in one year. Even if a Bowen-type catastrophic health plan were to pass Congress this year, it would not change the fact that a $520 deductible is too steep for many older Americans.

The National Committee recognizes that it is difficult to lower the deductible after it has been established at $520. In lieu of a reduction, we call for an immediate freeze of the Medicare Part A deductible. This would gradually reduce the payment to a more reasonable level in relationship to hospital costs.

Mandatory Assignment and Physician Fee Reform. The Administration's budget proposes to hold down doctors' fees in several ways, but fails at the same time to protect beneficiaries from doctors charging more than the Medicare-approved amount. These non-assigned fees average 25 percent more than the Medicare-approved amount. Since beneficiaries already pay 20 percent of the Medicare-approved amount, beneficiaries whose doctors do not accept assignment, on average, pay more than double of what other beneficiaries pay.

The National Committee agrees that physician fee reform is necessary, but it should go hand in-hand with mandatory assignment. A 1984 legislative compromise encouraged doctors to accept assignment 100 percent of the time. Unfortunately, only 29.8 percent participated in this new program and participation dropped two percentage points last year to 27.9 percent.

One of the Administration's proposals is to pay hospital-based physicians through an expanded DRG payment to the hospital. This does eliminate the problem of non-assigned fees, but the National Committee opposes any plan to expand this payment mechanism to the attending physician or surgeon. Doctors are one of the safeguards against hospitals dismissing patients quicker and sicker. Paying doctors through the DRG would give doctors financial incentives to go along with early discharges and conflict with Congressional intent to outlaw physician incentive plans in hospitals.

In evaluating physician fee reform, the most important goal is not reducing Medicare costs but implementing a fair payment system. Many doctors have taken financial advantage of Medicare, while others have suffered. The current payment system distorts the market for doctors' services because it encourages doctors to raise their fees, to choose specialty practices rather than primary care practices and to practice in higher income urban areas rather than rural or low-income areas. Physician fee reform means that Medicare will pay more for some services, while paying less for many other services. A fair payment system is needed to make mandatory assignment work without jeopardizing beneficiary access to care.

SOCIAL SECURITY STAFF CUTS - IMPACT ON SERVICE

Since its inception more than fifty years ago, the Social Security Administration (SSA) has always commanded respect for the way it has served the public. This reputation for service has depended on qualified, dedicated employees. Consequently, we are concerned about the impact on service to the public of reducing staff by 3,925 next year in addition to the 2,224 being reduced this year. This reduction is part of a five year plan announced in 1985 to eliminate 17,000 jobs over five years, a staff cut of 21 percent.

SSA professes to be able to reduce the number of employees and maintain an appropriate level of service on the basis of implementation of its systems modernization plan and increased employee productivity. Not only is SSA behind schedule in implementing the systems modernization plan, according to the General Accounting Office (GAO), but the undue emphasis on productivity means that employees frequently do not have the time to keep themselves up-to-date on changes in laws and regulations nor do they have sufficient time to insure that beneficiaries fully understand their benefit rights and obligations. In addition, Congress has recently added to SSA's workload by requiring all children over the age of five to apply for Social Security numbers. SSA also has a major new responsibility to verify Social Security numbers to aid employers in complying with the Immigration Amendments of 1986.

SSA is relying on partially tested computer software to come on line in time to rescue it from any misjudgement in staffing needs. Even then automation cannot replace personal contact nor substitute for a competent and experienced claims representative. SSA's emphasis on productivity, however, distorts the employee's priorities. When management measures employees by minutes on the phone and time spent interviewing applicants, claims representatives begin to cut corners to providing full and adequate explanations of benefits to beneficiaries.

Many of our correspondents indicate a total lack of understanding of how benefits are computed, when they are payable, the effect of early or delayed retirement on benefit entitlement, and how benefits are affected by post-retirement earnings. They are angry and resentful that rules applied retroactively are not what they were given to understand when benefits were started. They complain that they cannot get through on telephone lines or that responses to their questions are unclear. Social Security beneficiaries may be receiving correct answers to the specific questions they ask, but Social Security personnel may not be taking sufficient time to be sure the right questions have been asked or answered.

It takes time to adequately explain complicated eligibility issues to beneficiaries as well as to advise beneficiaries of their potential eligibility for SSI if appropriate. The Social Security Commissioner recently stated that SSA can do "more with less." Mr. Chairman, I don't believe that fewer employees can maintain the current level of public service, much less provide more.

OLDER AMERICANS ACT - NEED FOR MORE LONG-TERM CARE SERVICES

The Older Americans Act has served an important function in the lives of older Americans for the past 22 years. Through a network of state and area agencies on aging, nutrition programs and supportive services have been made available to older citizens across the nation. Not only does the Act provide needed services in the community and the home, it also serves to provide socialization for lonely individuals. A senior living alone may come to the local multipurpose senior center, provided for under the Act, to partake in the lunch program and at the same time get involved in a lecture or class. More and more seniors have come to depend on the services channelled through the Act. As the population ages, there is a need for more funding under this Act and we recommend increasing funding to the level of authorization, an 18 percent increase. Increased authorization, however, is needed for home delivered meals, the much smaller portion of the nutrition program, because spending is almost equal to authorization. Many seniors who depend on the congregate lunch program have now become frail and may no longer be able to leave their homes.

Adult day care. Adult day care is another example of a service necessary to meet the growing need of aging members of our society. Seniors may, for years, have attended nutrition and other activities at the senior center. No longer able to participate in the regular programs because of mental or physicial frailty, this person may attend the adult day care center within the facility. In this way the senior can still visit with friends at the center while participating in a program with a higher level of care. Only about 25 percent of the area agencies across the country subcontract for this service. Many frail seniors could benefit from an adult day care program.

This nation is estimated to have 2.5 million victims of Alzheimer's disease, many of whom are in the early stages of the disease and, therefore, still being cared for in the community. The family members of Alzheimer victims and other mentally and physicially frail older people desperately need respite services. Adult day care can provide a place to bring the dependent family member from a few hours a week to enough hours to enable the caregiver to work in a job outside the home.

Day care serves an important function for the frail elderly and their family caregivers. Their development and growth should be encouraged under the Older Americans Act as well as under Medicare and under special programs for Alzheimer victims. The National Committee urges Congress to give serious consideration to Congressman Panetta's H.R. 550 which would cover adult day care services under Medicare for up to 100 days. Senator Metzenbaum's S.81, which would provide new authorization for states to set up services to aid Alzheimer victims and their families, is also very interesting.

Home care. Whenever possible, home care has always been the preferred care for older people. But not until the implementation of the DRG system did it become absolutely essential that home and community care services be made more available. The demand for home health care has increased 37%

since the implementation of the Prospective Payment System. Yet Medicare is denying coverage for many of these services, unless the individual falls into just the right category of being sick enough to qualify for skilled nursing care and not sick enough to require constant care. The denial of Medicare reimbursement for home care places a much greater strain on other home care services such as those provided under the Medicaid program and the Older Americans Act.

While home care under the Older Americans Act is not skilled health care, in-home services clearly represent an expenditure priority for the Title III program. It is estimated that about one-quarter of all funds expended by area agencies go toward in-home services. While a substantial portion of these funds are spent on the home-delivered meals, almost an equal proportion are spent on in-home services such as housekeeping, personal care, and chore services.

The ability of the Older Americans Act to have a significant impact on the long-term care system is limited due to its relatively small level of funding as compared to other programs. However, many state and area agencies have made strides to improve long-term care services through hard work and creative coordination of many funding sources and existing programs. Some area agencies have developed care management and assessment systems and provide services otherwise unavailable to the frail population. In some states, the state and area agencies have been given responsibility for the administration of the Medicaid home and community-based waiver program. So although the amount of funding which Title III devotes to home care services is a small fraction of what is spent for home health services under Medicare and Medicaid, the program is flexible and functions to fill gaps in services for persons otherwise unserved. Because services under Title III are based on need rather than income or other strict criteria, the Older Americans Act services may be provided without the restrictions required under Medicare and Medicaid. It is this type of flexibility which is so desperately needed in our long-term care system.

The National Committee would urge Congress to commit additional funding for the Older Americans Act for home and community based care. We support Congressman Schumer's budget initiative calling for a $100 million increase in the Older Americans Act funding. It also calls for a clarification of home health care coverage under Medicare and more adequate post-hospital care including nursing home reform.

The President's budget proposal calls for the creation of a new block grant which would include Title III programs under the Older Americans Act. The National Committee has grave reservations about such a proposal for several reasons. First, the historic reality of the block granting of programs has had a bad precedence. Every time the Administration has created a block grant, it has seen fit to reduce funding significantly. Second, it changes the entire structure and priority of the Act which provides separate funding for the various titles. In addition to not being assured that the funding would be spent the way the Act originally intended, the federal government could also lose important information about trends in the aging population. This happened with the Social Services Block Grant. States were no longer required to report to the federal government how funds were spent.

Conclusion

We must move toward better health care protection and services for our older Americans. Our acute and long-term system of care is full of gaps. Rather than cutting and squeezing services further, it is time that we look for creative, sensible and compassionate ways to close those gaps. It is time that we take action to find adequate protection for our grandparents, our parents, ourselves. We look forward to working with Congress toward assuring this protection.

ITEM 14

National Governors' Association

Bill Clinton
Governor of Arkansas
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT FOR THE RECORD

OF

RAYMOND C. SCHEPPACH

ON BEHALF OF

THE NATIONAL GOVERNORS' ASSOCIATION

before the

SENATE SPECIAL COMMITTEE ON AGING

ON

THE ADMINISTRATION'S MEDICAID BUDGET PROPOSAL

March 13, 1987

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001-1572 · (202) 624-5300

The National Governors' Association strongly opposes federal Medicaid funding cuts such as the Administration's Medicaid "cap" proposal. Such federal funding reductions would severely compromise states' ability to meet the basic needs of our most vulnerable citizens. Federal cuts in Medicaid, by definition, are cuts in our nation's principal funding source of medical care for the poor, and long-term care for the frail elderly, and disabled. Federal responsibility for Medicaid and other basic means-tested programs is essential because individuals with the greatest needs tend to be concentrated in states least able to meet those needs.

We would emphasize that states are not in a fiscal position to offset federal Medicaid funding cuts. Due to weakened economies and resulting state revenue declines, many states have already been forced to cut spending below levels originally budgeted for this year. In fact, the 22 states indicated on the attached map have cut their budgets at least once this fiscal year. While the budget picture in the states is not quite as bad as it was during the depths of the recession in fiscal 1983, it has clearly deteriorated over the past two years. It is also clear that the situation will not be appreciably altered by changes in state revenues caused by federal tax reform. Even if states retained the full "windfall" created by federal income tax reforms, the average state windfall would make up only 1.5 per cent of state general revenues. This is, in part, because income taxes constitute only 17.4 percent of total state general revenues for the average state in fiscal 1985. However, under current gubernatorial proposals, the states will return 80 percent of this potential windfall to taxpayers, often in the context of reforms that will make state tax structures more progressive. Thus, governors intend to return to taxpayers $4.5 billion of the potential $5.6 billion windfall. These findings are drawn from a study completed last month by the National Association of State Budget Officers and the NGA; we are submitting a copy of that study for the Committee's information.

The remaining $1.1 billion of the windfall is heavily concentrated in states that cannot afford to return the full amount to taxpayers because of severe fiscal stress and poor economic conditions in the oil, mining, and farming sectors. Based on states' projections of Medicaid spending in fiscal 1988 under current law authority, the Administration's proposed cap on Medicaid benefits would cut $2.5 billion. Thus, cuts under the Medicaid cap would greatly exceed the $1.1 billion that hard-hit states are not able to return. Reductions would accelerate in future years because the cap would be indexed only for medical care price changes, and would not reflect factors that can substantially influence the need for Medicaid service. For example, the cap would neither be adjusted for growth in a state's frail elderly population, nor for increases in poor populations caused by downturns in an industry vital to a state's overall economy.

Federal funding cutbacks in Medicaid would be particularly unfortunate in light of reductions already made in Medicaid coverage of the poor. This erosion in coverage is most evident for women and children whose Medicaid eligibility has been based on AFDC program standards. For these populations, the income eligibility threshold for a family of three in the average state has declined as a percent of poverty from 71.4 percent in 1975 to 48.9 percent in 1987. The new flexibility Congress has given to states to offset this trend--by increasing Medicaid eligibility thresholds for pregnant women, infants, the elderly, and disabled--would be effectively repealed by the Medicaid budget cap. States simply would not be able to broaden eligibility within the proposed cap levels. States with relatively low eligibility standards would be unfairly precluded from improving their coverage of the poor.

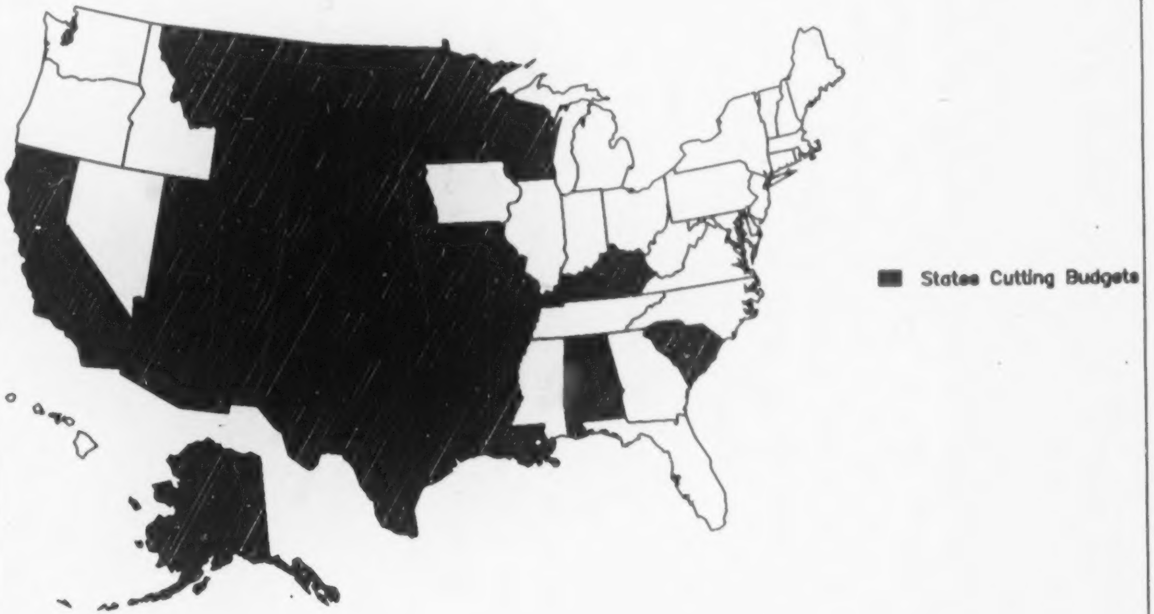
Nationally, the need for Medicaid coverage of the poor has never been greater. As Medicare, Medicaid, and private payers prospectively limit their payments to providers, and as purchasers increasingly seek to contract with networks of efficient and low-cost providers, much of the informal private-sector subsidy for care of the poor is disappearing. Health care providers are less willing and less able to shift costs of charity care through higher charges to other payers, and are often curtailing the provision of services to the uninsured poor. Because of these changes in the health care marketplace, Medicaid coverage has become even more critical in providing access to needed health care for the poor.

The members of this Committee are painfully aware that Medicaid is also virtually the only source of third-party coverage for long-term care. The fastest-growing segment of our population is that of age 85 and above, and individuals in this group are particularly at risk of needing long-term care services. The growth in need for these services is particularly great in those states that are experiencing substantial in-migration of the elderly. The proposed cap on federal Medicaid funding would greatly impair the ability of such states to meet growing long-term care needs. While the developing private insurance market has begun to offer mechanisms for persons with significant resources to purchase private coverage for long-term care, large numbers of even the "young" elderly cannot afford this protection. Because Medicaid requires that individuals be impoverished before coverage begins, and because long-term care costs constitute the single largest cause of catastrophic costs in this country, it is important that alternative financing mechanisms such as private insurance be developed. It is also critical, however, that the federal government not cut back on its Medicaid financing role for these services.

It is important to understand that the states already have a tremendous incentive to maximize cost-effectiveness and avoid unnecessary costs in their Medicaid programs. States, along with the federal government, share in any increases in Medicaid costs and, in fact, Medicaid often represents the largest state-administered program in state budgets. We have aggressively used the increased Medicaid policy latitude which Governors asked for and received from the Congress in previous years to contain costs. While the proposed Medicaid budget cut would reduce the provision of needed care for the poor, it is not needed to encourage efficiency on the part of state Medicaid program.

In summary, the Governors continue to strongly oppose reductions in the federal share of financing health care for the poor. These cuts will simply reduce the resources available to states for meeting growing health care needs of our most vulnerable citizens.

STATE BUDGET CUTS ADOPTED IN THE FISCAL 1987 BUDGET


■ States Cutting Budgets

ITEM 15

Statement of Curtis D. Cook,
Executive Director
National Indian Council on Aging

ADMINISTRATION BUDGET PROPOSALS: IMPACT ON INDIAN ELDERS

Mr. Chairman, and honorable members of the Senate Special Committee on Aging, thank you for inviting me to submit written testimony regarding the impact of the President's proposed budget on Indian elderly persons in America. I am Curtis D. Cook, Executive Director for the National Indian Council on Aging, an organization formed in 1976 for the purpose of advocating for the nearly 200,000 Indian and Alaskan Native elders in our country.

I am submitting the attached statement in rather abbreviated form for your ready reference, and will be pleased to provide any necessary documentation upon request.

My comments and responses to the administration's proposed budget for Fiscal Year 1988 should be viewed in the light of the continuing and almost incredible circumstances of the Indian elderly. These, who have contributed so much to their own cultures and their country in terms of values and traditions, exist within a milieu of daily deprivation, poor health, social isolation, inadequate housing, and a growing sense of futility which resigns them to the notion that things will never get any better. For anyone in our government, no matter what the motive, to propose a budget strategy which will further deprive the needy and vulnerable is simply to be oblivious to the fact that these are real people living in daily want and deteriorating health, and represents a kind of insensitive legislative genocide, which must not be tolerated.

Estimates of the percentages of Indian elders who exist today below the national poverty level range from 33% to as high as 61%. The conventional wisdom would tell us that the higher estimate is closer to being accurate.

Nearly one-third of the Indian elders live in dilapidated housing which is not only in need of repair, but also presents numerous hazards to their health and safety.

Indian elders typically suffer from hypertensive illness, diabetes, arthritis or kidney disease, and yet programs essential to their health and well-being are continually being targeted by the administration for elimination from the Indian Health Service budget. The net result of such philosophies as those which prompted Gramm-Rudman reductions is a dismal future for the grim Redman.

Those who are in a position to make decisions affecting the Indian elders and elders of other minority groups who are similarly deprived, need to take decisive action now to prevent further diminishing of much-needed services for those who are most needy.

You, respected members of the Senate Aging Committee, can become the agents of change for a better and more humane future for Indian and other minority elders by reversing the direction of administration proposals, and promoting significant increases in programs and services designed to meet their needs. We look to you, both for protection and solutions. The future of our nation's minority elders rests in your hands.

Thank you for your consideration of our testimony. God bless you all, and may He give you wisdom.

Respectfully submitted,

Curtis D. Cook

Curtis D. Cook
Executive Director
National Indian Council on Aging

Statement of Curtis D. Cook,
Executive Director
National Indian Council on Aging

ADMINISTRATION BUDGET PROPOSALS: IMPACT ON INDIAN ELDERS

PROPOSED CUT	IMPACT ON INDIAN ELDERS
Medicare ($4.6 billion cut)	Less than 50% of the Indian elderly now receive Medicare benefits. The proposed reductions in Medicare expenditures will mean less reimbursement dollars available for health care delivery by the Indian Health Service; both the quality and availability of services for Indian elders would be adversely impacted.
Medicaid ($19.5 billion cut over 5 years)	Only 20% of Indian elders needing institutionalization are in Skilled Nursing Facilities, normally paid for in part by State administered Medicaid dollars. Fewer resources w/ make nursing home care even more difficult to obtain. There are only 9 reservation-based nursing homes out of 504 tribes in the nation. Medicaid reaches only 46% of the elderly poor and only 17% of the Indian elderly poor.
Social Security (cut back 4,000 staff)	Fewer staff at Social Security offices will result in more difficulty in gaining enrollment, therefore less availability of assistance for Indian elders whose access is already extremely limited. According to NICOA studies, only 37% of Indian elders receive Social Security benefits.
Eliminate Congregate Housing Services Program	Indian elders, who already are living in substandard housing, need suitable alternative housing arrangements to facilitate a better living standard and closer monitoring of their health and safety status. Various needed services can be delivered more economically and efficiently in a congregate setting.
Community Services Block Grants	Community services, including emergency food and fuel assistance, are a life-line for many Indian elders (equivalent to the number who are below the poverty level) whose housing is unsafe and inadequate, and many of whom live in extremely harsh reservation climates.

PROPOSED CUT	IMPACT ON INDIAN ELDERS
Section 202 Housing	NICOA studies conducted as recently as 1986 have demonstrated that Indian elders typically live in hazardous and substandard housing. Elimination of any program which has, in the past, provided for some of their housing needs, will condemn Indian elders to a continuation of poor and unacceptable living conditions.
Weatherization	NICOA surveys in 1979 and 1986 revealed that nearly 1/3 of the homes occupied by Indian elders were constructed prior to 1939. The obvious conclusion is that many, if not all, of these homes will need weatherization to reduce excessive energy bills and to protect the elders from the elements -- temperatures typically drop below zero in the winter months in the geographic areas where most Indian elders live.
Low-Income Home Energy Assistance Program	The 1/3 cut proposed in the President's budget will obviously mean that 1/3 fewer services (energy assistance) will be available to elders who are likely to need them most. They cannot chop wood; they cannot repair stoves; and they cannot generate added income needed to avoid utility cut-offs.
Food Stamps and Nutrition	Reduction of benefits for persons who receive energy assistance is an approach which singles out the people who need the Food Stamps most; i.e., those who cannot pay their utility bills are likely to be those who are already in poverty. What kind of logic is there in this choice? "You can either choose to stay warm, or to eat, but you can't have both."
Older Americans Act Aging Research --------------- 50% reduction	This is the source (Title IV) which not only provides funding for research and demonstration programs, it is also the Title which supports the four national minority aging programs. If these advocates lose their funding, who will speak to America's conscience regarding its minority elderly who are clearly in the greatest economic and social need?

PROPOSED CUT	IMPACT ON INDIAN ELDERS
OAA Aging Research (cont'd)	At present there is a great paucity of research being conducted on Indian aging to complement the already limited data available. Without additional research to identify the factors which have mitigated against their health, life-expectancy and socio-economic status, the problems will continue and even be exacerbated as Indian elderly population grows, almost doubling in the 1980 - 1990 time period.
Older Americans Act Nutrition & Social Services	Forget the so-called "safety net," the OAA programs, which provide nutrition and supportive services to poor and minority elders who are in the "greatest economic and social need," are a veritable life-line to those Indian elders who are fortunate enough to receive these services. But 7/8 of the reservation elderly population are not served at all by OAA programs which are to be targeted toward them (among others in need). Title III, which is the only federal program providing these services to Indian elders off the reservation, has an Indian elderly participation rate of less than 1% of the total participants. The services, already inadequate to meet the needs of Indian elders, would become less available to some of these who need them most if there were to be any further reduction in available resources.
OAA "generic appropriation"	The administration's proposed "generic appropriation" is nothing more than a block grant which would eliminate the specificity of the programs now provided under the various titles of the Act. The loss of such specific requirements of the law to provide designated services at specific funding levels, will further discriminate against Indian elders who are supposed to be a targeted group under the Act, but are even now unserved or underserved.
OAA $34 million reduction	If any portion of the proposed $34 million reduction comes from programs serving Indian elders (Titles III, IV, V and VI), it will further reduce the availability of services and the number of elders being served. They are already underserved or unserved. We're going in the wrong direction.

PROPOSED CUT	IMPACT ON INDIAN ELDERS
OAA Eligibility	The administration's proposal to change the eligibility age for Older Americans Act services from 60 years to 70 years will directly discriminate against the elders of all of the four major minority groups in the country, for minority life expectancy is less than 70 years. Minority elders (especially Indian elders) are already underserved by OAA programs, even under the present requirements of the law that services be targeted toward low income and minority groups. Any further obstacle to their receiving services must be strenuously opposed.
Indian Health Service Budget Reductions	Indian elderly people already suffer from the poorest health status of any ethnic subgroup in our nation. Certain programs, upon which they are dependent for much-needed health care (eg., urban Indian health clinics, and Community Health Representative programs), have been consistently designated by the present administration for elimination from the IHS budget. The majority of Indian elders do not have the resources to seek medical care from sources other than the IHS hospitals and clinics. Further reductions in services can only result in a worsening of their health conditions. Rather than a reduction in funds and services, extraordinary measures are needed to bring about significant improvements in their health status. Planned, comprehensive, community-based health delivery systems are needed to provide the continuum of care which will assure that the necessary improvements become a reality.

ITEM 16

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STATEMENT OF NATIONAL SENIOR CITIZENS LAW CENTER
BURTON D. FRETZ, EXECUTIVE DIRECTOR
EILEEN P. SWEENEY, STAFF ATTORNEY

**Before the
SPECIAL COMMITTEE ON AGING
of the
UNITED STATES SENATE**

March 13, 1987

Mr. Chairman and Members of the Committee:

The National Senior Citizens Law Center is pleased to accept the invitation of the Committee to comment on the Administration's proposed budget for FY 1988 and its impact on the elderly poor. The Law Center is a national support center which specializes in providing legal advocacy and specialized support on problems affecting older Americans of limited income. The Law Center assists legal services, private attorneys rendering pro bono services, and other representatives of older clients under the Older Americans Act. Our staff responds in over 3,000 cases yearly from across the country in areas such as income security, health care, employment rights and other matters of basic subsistence for older Americans. In this context, we are happy to comment on the proposed budget for FY 1988.

Los Angeles Office: 7th Floor, 1052 West 6th Street, Los Angeles, California 90017 • (213) 482-3550

Recent census data indicates that about 5.8 million persons above the age of 65 are classified as poor or "near-poor" who have income at less than 125% of the federal poverty level. The average income in 1985 was $10,900 for older men and $6,313 for older women. Moreover, the General Accounting Office reports that only half of the elderly with incomes below the poverty line receive public assistance, making their individual circumstances particularly dire.

The proposed FY 1988 budget would have a harsh impact on older persons with limited income. Some of the programs for low income elderly most affected include the following:

- Social Security -- The proposal would cut funding for the Social Security Administration which, according to some estimates, could require staff cuts of $4,000 next year and a total of 17,000 positions by 1990. These cuts would have drastic effects on the elderly population, and these are discussed further below. On October 1, 1986 the Administration came under additional legal responsibilities whereby its district office staff must assist applicants and recipients of supplemental security income in filling out a simple food stamp application and forward it to the local food stamp office. This comes about through recent amendments to the Food Stamp Act intended by Congress to minimize problems of access, long waiting lines and complicated food stamp applications presently faced by many older persons by making available a streamline one-stop application process in the Social Security Office. SSA staff cutbacks would hinder the implementation of this important new program.

- Nutrition -- The proposal would cut approximately $300,000,000 from the federal food stamp program by lowering benefits for persons who receive energy assistance -- of which older households compose a significant part -- and by imposing additional penalties on states through changes in the food stamp error rate.

- Medicaid -- The proposal would place a permanent cap on Medicaid, beginning with a $1 billion cut next year. Medicaid is the only real source of long-term nursing home care for the elderly poor, and this important source would diminish substantially under the proposal.

- Medicare -- The proposal would increase the Part B premium for new Medicare beneficiaries by more than one-third. The Part B deductible amount would increase each year tied to the rate of the Medicare economic index. Eligibility for Medicare would be delayed for one month. Recent Medicare expansions covering optometrists, occupational therapy, physician assistance and kidney dialysis would be repealed, despite the need among Medicare beneficiaries for these important health services.

- Legal Services -- The Administration proposes once again to abolish the Legal Services Corporation, which currently provides legal representation to many low-income persons including approximately 150,000 elderly poor clients each year. The current funding level is $305.5 million dollars.

- Housing -- New housing construction would be eliminated under the proposal, including S202 Housing for the elderly and handicapped. Although the Administration has proposed an expanded voucher program to permit the elderly and handicapped to seek out housing in the private sector, the nonexistence or the shortage of available housing through the private sector makes the voucher program benefits very speculative.

- Weatherization -- The proposal would terminate the weatherization program for low income people by providing no federal funding in FY1988. The program helps particularly low income elderly households by making their homes more energy efficient and reducing future energy costs. In addition, the budget proposal would cut funding by more than one-third from the Low-income Home Energy Assistance Program.

- Older Americans Act -- The proposal would cut by one-half funding currently made available for support and demonstration projects under Title IV of the Older Americans Act. Moreover, the proposal would freeze all other funding under the Act for elderly meals, services and employment at a time when modest amounts of increased funding are greatly needed.

We express particular concerns about the likely impact of the proposed 1988 budget in two areas: its limitation on much-needed legal services under the Older Americans Act, and the constraints on operations under the Social Security Administration which it would cause.

Older Americans Act

The American Bar Association Commission on Legal Problems of the Elderly issued a White Paper in January of 1987 discussing the legal needs of limited income older Americans and how those needs can be met more effectively under the Older Americans Act. The major finding in the White Paper is the steadily rising need for legal help for older Americans and the steadily declining availability of this help under the Act. It found that older persons' legal needs went to "survival" issues involving complex procedures in areas like Social Security retirement and SSI, Medicare, Medicaid, nursing home and health care needs, and other government programs critical to income and health security of older Americans.

Despite these growing needs, funds for legal help under the Act have declined nearly 50 percent since 1980, after adjustments for inflation. At a minimum, the White Paper recommends that this shortfall be restored.

Since the 1970's, the Older Americans Act has contained authority and direction for the provision of legal assistance. The White Paper contains a description of the system, the legal problems currently facing older people, examples of how legal assistance providers resolve these problems, and recommendations for changes to make the Older Americans Act more cost-effective.

Using formulas developed by programs under the Legal Services Corporation, we estimate that approximately $87 million is necessary to achieve minimal access to legal representation needed by the elderly poor and near-poor in this country. The level of current legal assistance is about half that level, and only $10 million of this is funded through the Older Americans Act. Because the Administration's proposed budget freezes all funding under Title III, it becomes impossible to consider even modest increases to meet the overwhelming need for assistance. Moreover, other vital services such as nutrition, in-home care for the elderly, and employment also are frozen at current levels under the budget proposal.

We are also very concerned about a number of problems, allegedly created by budgetary constraints, at SSA which the proposed budget would exacerbate.

SSA Staffing Issues

SSA staff are working under very trying circumstances. Regardless of how well-intended they are, the staff cuts, limits on office supplies and increases in their workloads inevitably lead to reductions in the quality of service which the public receives. As we assume that others who are testifying will address this issue, we want to focus on three points that may not be raised by others.

First, NSCLC has recently had the opportunity to scrutinize carefully, in the context of litigation, the estimated work-year savings which SSA allegedly intends to realize if three courts permit it to stop using the claims file in determining whether a person is entitled to waiver of recovery of a Title II overpayment.[1] In the overall picture, the work-year savings here are modest compared to those it allegedly intends to realize from its various modernization projects. However, the method it used to create its estimate here suggests the existence of serious flaws in SSA's overall estimates. As these estimates provide SSA with its justification for cutting staff positions based on future estimates while also substantially increasing the workload, all while claiming quality of service will not suffer, the experience with the Buffington estimates is instructive.

Documents supplied in Buffington reflect that SSA expects to save 226 work-years annually if the courts grant its motions.[2] (The document is attached.) The document, written by Sherwin T. Montell,[3] includes numerous erroneous assumptions.[4] When questioned about this at a deposition, SSA agreed that the assumptions were incorrect and essentially dismissed the validity of the work-year estimate. Portions of the deposition are set out in the appendix to this statement.

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[1] SSA has filed motions to this effect in Buffington v. Bowen, Civil Action No. 734-73C2 (W.D. Wash.); Yamasaki v. Bowen (D. Haw.); and Mattern v. Bowen (D. Pa.). The issue originally giving rise to these cases was decided by the Supreme Court in Califano v. Yamasaki, 442 U.S. 682 (1979).

[2] See memo from Sherwin T. Montell to Paul Tracy, attached hereto.

If this is the shoddy nature of the estimates which SSA creates even when it knows the issue will be subjected to judicial scrutiny, the Congress should view as highly suspect any mega-estimate that is essentially the accumulation of similar, smaller flawed estimates.

Second, SSA's answer to almost any service question is that it is increasingly relying upon the telephone. A person can call to ask questions, to apply for benefits, to report changes in circumstances. There are at least two major problems with this: (1) the phones are invariably busy, even after repeated attempts to reach SSA; and (2) SSA has a policy of discarding many of the documents which would prove that a person telephoned to report a change in circumstances. As a result, the innocent beneficiary later discovers that SSA holds him/her to blame for failing to report the information despite the fact that she/he did report.

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[3] At deposition, SSA representative Paul Tracy described Mr. Montell's credentials as follows:

> Mr. Sacchetti (SSA attorney): The people who made these estimates, could you describe your understanding of who they are and what their background is?
>
> The Witness (Mr. Tracy): Well, basically these are financial management people whose jobs is to price out different functions, ongoing functions, proposed functions, to in effect put together budgets and activities like that who are highly experienced and have their expertise in work power savings and costs.

Deposition of Paul Tracy, p.35 (November 5, 1986).

[4] Among the incorrect assumptions are: (1) no person seeking a waiver of recovery of the overpayment would request to see his/her file before the hearing; (2) all people seeking waivers would have their hearing on the same day as they filed their request for waiver; and (3) no review of decisions made by the district offices. (By "incorrect" we mean that the assumption was inconsistent with and contradictory to the representations which SSA had made about the proposed procedure in dealings with the plaintiffs' counsel.)

Third, there are a wide variety of SSA service problems, all of which have been exacerbated by the staff cuts. We urge this Committee to consider the need for a legally enforceable Bill of Rights for Social Security and SSI beneficiaries and contributors.

SSA/OHA Budget Issues

One area of concern that has gone virtually unnoticed so far by the Congress is the pattern of behavior developing in the Office of Hearings and Appeals at SSA. OHA is the office within SSA which includes the federal administrative appeals levels: the administrative law judges (ALJs) and the Appeals Council. OHA has offices throughout the U.S. at which ALJs hold hearings and from which they travel (to some extent) to hold hearings. NSCLC is very concerned about the reports which it continues to receive which suggest total indifference by OHA and SSA, and perhaps outright hostility, to the needs of the populations its offices serve. A few examples suggest that there is a need for a major investigation into their recent practices:

1. The New Orleans OHA office is currently located in a business area in a black community; it is easily accessible to public transportation. OHA recently announced that it is moving the office to the suburbs, to all-white Jefferson Parish. This is the parish where, in recent months, the sheriff made national news when he announced his intent to search all black people coming into his parish as they were suspect. Most recently, The Washington Post carried an article reporting that Jefferson Parish had agreed to take down the wall it had built on its border with the city (see article attached).

   Needless to say, the new site also is not at all convenient to public transportation.

2. In Los Angeles, advocates tell us that one OHA office has moved into a building where parking costs $12.00. As SSA only pays travel costs where the person travels over 75 miles each way to a hearing, this ridiculously high cost must be borne by the disabled person or must park two blocks away and attempt to walk the distance. (Of course, if a person does and makes the two block walk, regardless of how difficult it was, SSA will hold that against him/her in determining eligibility.) OHA is also attempting to move its Watts office out to the suburbs, away from the people it serves and away from accessible public transportation.

3. In recent years, OHA has created "travelling ALJs." These ALJs appear at an OHA site, usually for one week, hold hearings and then return to their home offices to prepare and issue the decisions. In order to make these trips cost-effective, it appears that SSA requires that the ALJ conduct a specific number of hearings, in the area of one every 30 minutes. Advocates (both legal services attorneys and members of the private bar) have expressed their concern to us about the practices of these ALJs. They see these ALJs taking short-cuts that seriously impair the evidentiary records in these cases. For example, some travelling ALJs refuse to call vocational experts (VEs) to appear at the hearing, even though SSA's own regulations require the use of a VE in the case. The questioning and cross-examination of a VE take time. Calling a VE in one case will result in delays in the ALJ's already overbooked schedule. So, quality is sacrificed to short-term, but also short-sighted, cost-effectiveness. It is likely that a court will reverse the ALJ upon appeal and remand for a new hearing which includes a VE, all at significant, unnecessary cost to SSA.

   In a second example, we recently received a call from a legal services attorney in North Carolina. After the travelling ALJ (from Puerto Rico) held the hearing in North Carolina, he sent the attorney a notice that he intended to depose a medical adviser in Puerto Rico about the case. Needless to say, very few people and certainly no client of a legal aid program can afford to send their attorney to Puerto Rico to cross-examine the medical adviser. It would have been far more appropriate, and much more fair, for the ALJ to have taken the time at the hearing in North Carolina to hear the testimony of a medical adviser.

Budget Cuts In the State Disability Determination Services (DDSs)

Virtually all disability determinations on applications and continuing disability reviews are initially made by federally-funded state agencies, the disability determination services ("DDSs"). After HHS/SSA and OMB pressed the Congress to cut SSA's administrative budgets, SSA turned around and told the states that the Congress' changes meant that the states would be required to dramatically increase their "PPWY"s (per person work years) in order to handle the caseload SSA plans for them. This notice came in the midst of massive DDS regrouping to address new statutory and regulatory rules (in the 1984 Act) for adjudicating the mental impairment cases, the CDRs (continuing disability reviews), and overall claims file documentation rules.

While the emphasis of the 1984 Act, numerous court orders, and various regulations (particularly the mental impairments listing), is upon high quality decisions based upon well documented files and special emphasis upon treating source evidence, the message of the PPWYs is just the opposite: cut corners, reduce quality, and squeeze more decisions out of each DDS employee. When asked about these issues, SSA staff cite improvements in the claims adjudication process and dismiss the DDSs' concerns to greed and laziness. However, from our perspective, regardless of what magic SSA claims it can work with the numbers, the DDSs' claims that the quality of decisions is going to suffer must be taken very seriously.

A few examples from the DDSs suggest just how serious the problem is:

1. The head of the Texas DDS has written to Senator Bentsen, in a letter dated January 21, 1987. (A copy of the letter is attached.) He states:

   A. "[T]he budget situation [at the DDS] has continued to deteriorate."

   B. As a result of SSA's "midcourse corrections" in how the mental impairment reforms are implemented "the allowance rate has steadily decreased from an all-time high in January [1986] of 67.8% to a low of 30% in December [1986]. Accordingly, members of our state agency medical staff, the private medical community, and others are beginning to question SSA's commitment to reforms in the evaluation of claims involving mental impairments."

   C. The Texas DDS has not yet implemented face-to-face hearings at the reconsideration level "due to inadequate funding." "As a result, those beneficiaries who have appealed the limited CDR cessations which have been processed have not been afforded the opportunity for a face-to-face hearing to date."

   D. As a result of these problems, Mr. Arrell, the head of the DDS, informed Senator Bentsen that the Texas DDS is considering acting to (1) suspend processing of CDR cases, (2) postpone the face-to-face at reconsideration process, and (3) initiate storage of new initial application cases.

2. In California, where the DDS hierarchy apparently is pretending it can meet SSA's quotas but its staff is worried, the DDS has ordered its non-physician lay adjudicators to make the residual functional capacity (RFC) determinations which SSA's own regulations say only a doctor can make. See 20 C.F.R §404.1546. [42 U.S.C. §421(h) requires that a psychiatrist or psychologist make the RFC determination where a mental impairment is involved.] The DDS then has a physician just sign-off on the RFC determination. One California physician, upset by this new policy, has written:

   > Management will attach a note to the chart ordering the medical consultants to adjudicate the claim according to the dictates of management, no matter what the real issue is. The note is than [sic] remanded prior to the charts completion, so that in the final analysis, it appears that the medical consultant acted independently.

   (A copy of the letter of Richard A. Gilman, M.D., is attached.)

On this issue, in reply to a question regarding quality, SSA will indicate that its review shows that the DDSs have an overall rate of accuracy of some percentage in excess of 90%. It is important to note that, at the height of the CDR scandal, SSA still claimed it has accuracy ratings in excess of 90%.

Finally, we believe that the members of Congress are concerned that the provisions of the 1984 Act be implemented fairly and completely. In recent weeks, the Ways and Means Committee has written to Commissioner Hardy indicating its concerns on both SSA staffing cuts and DDS issues. With regard to the latter, Representatives Rostenkowski, Pickle and Jacobs stated:

> "...[S]ome states argue...that continued underfunding and understaffing will make it impossible for State agencies to correctly apply the new standards to both initial and continuing review cases."
>
> "These problems contribute to a continued atmosphere of crisis, and confound the fundamental goal of the 1984 amendments--the restoration of order and stability to the program."

> "If State agencies are forced to cut corners and speed decision-making without thorough case development, the problems of poor documentation and inconsistent determinations will continue to plague this program. The long-term objectives of the 1984 amendments should not be sacrificed to satisfy minor, short-term savings in the administrative budget."

In addition, Senator Kerry and Representative Frank have introduced identical resolutions, S. Con. Res 13 and H. Con. Res. 35, which state the "Sense of Congress" that SSA should not reduce [illegible] taff or increase their caseloads "to levels that would [illegible] it adequate case development in accordance with the standards" in the 1984 Act or "initiate any other action that would impair the ability of the examiners to determine eligibility for benefits in accordance with the requirements" of the 1984 Act.

Additional Areas of Concern

There are two other problem areas that we suspect are budget-related but which have not yet received the attention they deserve:

1. **Face-to-face interviews at the initial level**: In 1984, Congress required the Secretary to conduct demonstration projects on the feasibility and value of the DDSs conducting an initial face-to-face interview with the disabled person prior to deciding the issue of eligibility or continued eligibility. These projects are extremely important. If done properly, they will permit the Congress to assess the advantages of interviews at the initial stage versus the reconsideration level of review.[5]

   While we do not yet have all the details, we have been informed that SSA is not giving high priority to these projects, that the training of staff has been inadequate. There apparently also are questions about the quality of the work being done by the contractor SSA has hired to evaluate the projects. Given how important these projects are to critical policy decisions which will face the Congress in the near future, this Committee may

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5. Face-to-face hearings at the reconsideration level were mandated in 1982. See §§4 and 5 of P.L. 97-455. [§4 is codified as 42 U.S.C. §405(b). §5 is included in the notes after §405.]

wish to inquire further into SSA's actions in this area.

2. **Attorneys' fees for the private bar**: It is now a fact of life for disabled people that attorneys (or paralegals supervised by attorneys) are needed in order to successfully wend one's way through the complex of procedures and standards in the Titles II and XVI disability programs. At the same time, SSA seems determined to discourage the private bar from representing disabled people by delaying payment of fees, and changing the rules of the game regularly, generally without notice and comment or even publication.

   As a legal services support center, we provide legal support to both legal services and aging advocates and members of the private bar representing low income elderly and disabled individuals. Along with local legal services programs, we are very aware of the critical role which the private bar serves in representing the disabled before SSA. It would be impossible for legal services programs to represent all of these individuals if the members of the private bar that specialize in Social Security were to begin to shift their practices out of this area. While we recognize that, at first, this appears to be an attorney payment issue, the issue is far more significant: as SSA has already realized, without high quality legal assistance, many disabled people who are eligible for benefits will not receive them, thereby illegally saving money. We urge the Committee to hold hearings and consider possible legislative solutions to this problem.

It is critical that the Congress continue to monitor these issues. In the past, this Committee has played a critical leadership role both in documenting the problems and formulating the solutions. We urge it to continue these vital efforts.

APPENDIX

1. SSA had not done any alternative estimates that took into account more realistic assumptions about how the process would work: "...[T]his was basically pricing out the process that I've described. I don't believe we have done the variations on that in terms of pricing out." Deposition of Paul Tracy, p.29 (November 5, 1986)

2. "...[T]his was simply done for purposes of some kind of pricing out of the proposal and certainly would be only an assumption for that purpose." Deposition of Paul Tracy, p.30 (November 5, 1986).

3. In reply to a question on how SSA determined that its district offices would contact the program service centers in 16% of the cases, SSA replied:

> "I don't know what specifically went into that particular estimate. It would seem like there could be a variety of things. These were obviously, incidentally, made by one staffer saying this is the way I would picture the process working and giving estimates of what they would anticipate. Where the 16 percent came from, I cannot tell you. It probably is someone's best estimate based on past experience or something like that."

Deposition of Paul Tracy, p.31.

4. With assistance from SSA's counsel, Mr. DePass, Mr. Tracy tried to distance SSA even farther from its own work-year estimate:

> Mr. Depass (SSA attorney):...Maybe we ought to state clearly for the record what was the purpose of that particular letter or memorandum? What was it trying to show or project?
>
> The Witness (Mr. Tracy): All it was trying to project was what would the work years--what work year savings would be involved were we to move from

> one type of process to the proposed type of process.
>
> * * *
>
> The real purpose is simply to give the decision-maker some estimate as to what kind of work power is either being saved or expended on a given thing.
>
> Since it's not an in-effect thing, it obviously has to be based on people's best estimates or guesses as to what the expenses of the different steps of the process would have to be.

Deposition of Paul Tracy, p.34.

5. And finally:

> Ms. Sweeney (plaintiff's counsel): Is it safe to assume that when somebody makes estimates like this that SSA is going to rely upon that they try and find out something about the process they're making the estimates on?
>
> Mr. Tracy: I'm not sure I understand that.
>
> Ms. Sweeney: I think they [SSA] relied pretty heavily on these work year estimates and I assume the folks within SSA who make decisions about work year estimates...had to know exactly what the rules of the game are, what SSA plans to do, before they can make those types of judgments.
>
> Mr. Tracy: Well, for purposes of decisionmaking, you may not know all of the--you know there are savings involved, of certain operations being virtually eliminated or reduced. I don't think that anyone ever pretends that they can know with certitude what those are going to end up with, but what they're looking at is basically a best guess as to what the operation should entail.

Deposition, pp.34-35.

SMF-11

[illegible]

FM-4

TO: Mr. Paul Tracy
Division of Benefit Continuity

SUBJECT: Folderless Waiver Process and Proposal for Verification of Certain Allegations of Income, Assets, and Expenses in Waiver Decisions--INFORMATION

The Office of Financial Resources (OFR) has reviewed the attached plan for the folderless waiver process and the proposal for verification of certain allegations of income, assets and the expenses in the waiver decision process. The estimated administrative savings would be approximately 226 workyears annually. OFR developed the cost estimates based on the process and assumptions provided to us by the Office of Retirement and Survivors Insurance.

If your staff have any questions, they should call Elnora Wardlow on extension 45567.

Sherwin T. Montell

Attachments

SMF-11:EWard[illegible] 4/24/83
(CCB:DAB-13-[illegible]

Folderless Waiver Process and Verification of Certain Allegations of Income, Assets, and Expenses in Waiver Decisions

Current Procedure

DO

--Assists debtor in completing Overpayment Recovery Questionnaire (SSA-632-F-4).

--Advises debtor of additional evidence and required verification needed to make a decision on its waiver request.

--Explains waiver decision will be based on the evidence presented and information contained in folder.

--Inputs stop recovery action to ROAR.

--Informs debtors that he/she will be notified of the decision and a personal conference will be scheduled if the waiver request is denied.

--Receives from PSC the debtor's folder and PSC worksheet if the waiver request is denied.

--Reviews information received from PSC.

--Contacts debtor to schedule a folder review and a personal conference.

--Holds scheduled folder review session and/or personal conference.

--Prepares determination (SSA-553) based on personal conference.

--Sends folder and determination back to PSC for review and effectuation of decisions.

--Eighty-five percent of the title II waiver request volume is subject to income, resources, and expense verification.

OPSC

--Reviews waiver request, evidence submitted by debtor, verification data provided by DO and folder.

--Recommends waiver approval or denial.

--Notifies debtor if waiver is approved and effectuates the decision.

--Prepares overpayment worksheet and send worksheet and folder to DO to schedule personal conference if waiver is denied.

--Reviews personal conference procedures, DO determination, and letter prepared by DO.

--Return to DO for review if it disagrees with decision, procedure used or letter content.

--Release letter to debtor of waiver decision and effectuate decision.

--Input decision into ROAR.

Assumptions

DO

--Implementation date has not yet been established.

--All RSI waiver decisions will be processed in the DO without a folder.

--DI cases will continue to be processed under current procedures.

--Assumes initial interview and personal conference are done at the same time.

--Assumes DO will be able to make decision based on information obtained from the PHUS and MBR (PHUS will provide information on what was paid and the MBR will provide information on what should have been paid).

--All title II waivers except (approximately 1.4 percent) those which appear that the person will be found at fault. The OA National Waiver Study indicated that these items are most often subject to misrepresentation by the waiver applicant. This 98.6 percent of the cases will be verified as opposed to the current procedure of requiring verification of only 85 percent of the cases.

PSC

--Assumes PSC's will no longer review and make a determination on RSI waiver requests.

--Assumes worksheets will no longer have to be prepared when a waiver request is denied.

--Assumes a review of the personal conference procedure, DO determination, and letter prepared by DO will no longer require a review.

--Assumes DO will have to contact PSC in 16 percent of the cases for additional information i.e., dates of due process notice because the information can only be obtained through reviewing the folder.

Volumes

--Approximately 90,000 RSI waivers were processed in FY 1984.

--Assumes 81,900 RSI waivers in FY 1985 and thereafter because overpayments and a corresponding volume of waivers are reduced as a result the AET process which prevents overpayments to certain beneficiaries and the revised enforcement process which adopted a $50 overpayment tolerance effective August 1, 1984.

--Assumes 5,300 additional title II cases will need income, resource, and expense development by the DO.

--Assumes DO will have to contact PSC for additional information in 16 percent of the cases (13,100).

Unit Times

--Estimated unit times were established based upon discussions with OCO, OMPA, and DMS.

PSC - 165 minutes to process waiver
- 15 minutes to respond to DO requests for additional information

DO - Average time to hold a personal conference is 126 minutes. The estimate assumes under the proposed one-step process the time spent on preparing and holding this second interview will be eliminated.

- 35 minutes additional DO time to make the waiver decision.

- 45 minutes for additional cases which will require income, resource, and expense development.

	Volume	Unit Time	Total WY's
DO			
Elimination of Personal Conference on Waivers Denied......................	30,300	126 min	-62
Folderless Waiver decision....................	81,900	35 min	+47
Additional Developments.......	5,300	45 min	+4
Total..			-11
OPSC			
Elimination of Processing of Waivers..................	81,900	165 min	-220
DO Contact to PSC for Additional Verification......	13,100	15 min	+5
Total..			-215

"A HUMAN ENERGY AGENCY"
TEXAS REHABILITATION COMMISSION
VERNON M. ARRELL, Commissioner
118 East Riverside Drive • (512) 445-8108 • Austin, Texas 78704

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January 21, 1987

The Honorable Lloyd Bentsen
United States Senate
SH 703
Washington, D.C. 20510

Dear Senator Bentsen:

In October 1984 the Congress passed the Disability Benefits Reform Act (Public Law 98-460). Over the past two years I have tried to keep you informed of the status of the disability reforms mandated by this legislation.

On July 29, 1986 I reported to you my concerns about budgetary restrictions, increasing caseloads, and staffing cuts. As we enter a new year, I regret to inform you that the budget situation has continued to deteriorate.

The Social Security Administration (SSA) has cut the Texas Disability Determination Division (DDD) budget by $3.1 million and staffing level by some 80 staff positions since May 1986. At the same time, a national production per workyear (PPWY) standard of 195 was imposed.

Fiscal Year 1987 workyear limitations set by SSA would force us to cut a total of about 100 staff positions to reach the required average staffing imposed by SSA. This would include losing 35-40 positions from our current staff levels. Despite being "overstaffed" in SSA's view, Texas continues to significantly exceed the SSA standards for this size organization with an estimated 220 PPWY.

1986 Performance

The downturn in the Texas economy during the past year has contributed to record numbers of disability applications. At the close of FY 1985 DDD had a pending inventory of 24,236 claims. We closed out FY 1986 with an inventory of 31,739 claims, or a 31% increase.

DDD received a record 173,497 disability claims during the year. We set an all-time monthly receipt record last March, then surpassed it with new records in April, September, and October.

DDD has accomplished a record level of case clearances for the past eight months. Despite the workload pressures, our employees have maintained a high level of productivity. We set an all-time monthly clearance record in July and then surpassed it in October. We are deeply committed to our responsibility of serving disabled people, but the strain of this overload is taking its toll. We cannot sustain this production indefinitely as we continue to lose staff.

An Equal Opportunity Employer

Mean processing time for Title II SSDI cases in Fiscal Year 1986 was 65.7 days compared to 46.4 days in Fiscal Year 1985, a 41.6% increase in processing time required to serve persons with mental and physical disabilities.

Processing time for Title XVI SSI cases was 68.4 days compared to 50.3 days the prior year, a 36% increase.

Several months after the introduction of reforms in the processing of mental impairment claims, SSA implemented "midcourse corrections" in the way these claims are evaluated. As a result, the allowance rate has steadily decreased from an all-time high in January of 67.8% to a low of 30% in December. Accordingly, members of our state agency medical staff, the private medical community, and others are beginning to question SSA's commitment to reforms in the evaluation of claims involving mental impairments.

Continuing Disability Reviews

Appropriate funding for state disability determination agencies would have allowed the disability program to fully resume the Continuing Disability Review process many months ago. Around the country thousands of beneficiaries who have medically improved would be well on the way to cessation of benefits. The savings to taxpayers and the trust fund would more than make up for the slight increase in funding for state agencies.

The Disability Hearings process legislated by the 1983 Amendments to the Social Security Act has not been implemented in Texas due to inadequate funding. As a result, those beneficiaries who have appealed the limited CDR cessations which have been processed have not been afforded the opportunity for a face-to-face hearing to date.

Disability Determination Services administrators throughout the country are raising their voices in protest over the staffing/budgetary crisis and the impact to the people we serve. A November 1986 report by the Council of State Administrators of Vocational Rehabilitation (CSAVR) confirms that these problems are being experienced nationwide.

Texas Action Plan

It is the goal of the Texas DDD to provide accurate and timely disability determinations for disability claimants in the State of Texas. We will not compromise development, documentation, and quality by stretching our staff beyond its limits.

With no relief in sight and additional cutbacks projected for Fiscal Year 1987, the Texas Rehabilitation Commission has developed an action plan to address the crisis we are facing. Measures of the plan could potentially include:

- limiting daily case assignments to disability examiners
- putting a maximum limit on cases assigned to disability examiners at any given time
- suspending the Continuing Disability Review process
- postponing the Office of Disability Hearings program to allow hearings officers to assist with initial case adjudication
- initiating storage of incoming initial cases

Conclusions

With the passage of the Disability Benefits Reform Act of 1984, Congress passed a strong bill designed to restore credibility to a disability program fraught with controversy. Input was submitted by the public sector toward the development of comprehensive plans and procedures to implement the provisions of the legislation. Expectations were high.

With the budgetary/staffing crisis, we are in danger of dismantling "the new era in the disability program" which was so painstakingly crafted by Congress, SSA, Disability Determination state agencies, the medical community, and advocates for the disabled.

We are supportive of SSA's current initiatives toward work simplification. This streamlining effort will be beneficial, but we do not believe it will counter the loss of 80 disability examiner and support positions.

The Texas Rehabilitation Commission has consistently delivered a message to SSA: We cannot administer a more comprehensive disability program with record levels of case receipts and do it in a quality way with 10% less staff.

The decision to initiate the measures outlined above was made after much soul-searching. Suspension of CDRs and postponement of the Disability Hearings process will allow us to dedicate our efforts to the processing of new disability claims. However, the trust fund will be negatively impacted as individuals who are no longer disabled continue to draw benefits.

If case storage is initiated, it will result in significant delays in decisions for new disability applicants. This is regrettable. However, we cannot allow disabled citizens to suffer because of inaccurate decisions brought on by inadequate funding. Bringing disability examiner caseloads to manageable levels should help preserve our standards for decisional accuracy.

I hope that the actions we are taking will be temporary and that soon we will be granted the resources to efficiently administer this vital program which impacts the lives of many disabled Texans. I would appreciate your assistance as we make the difficult decisions necessary to address these problems.

We share Commissioner Hardy's commitment to cost effectiveness, accountability and integrity of the Social Security Disability Program. We believe the Texas DDD record reflects that commitment and performance. It is important for the success of this program and this partnership for the Social Security Administration to show respect for those Disability Determination state agencies performing in an outstanding manner by providing adequate funds to sustain that level of performance.

I will continue to keep you informed as program developments occur. Our Inquiries Services staff (512-445-8681) is available to assist you and your staff members in responding to the questions and concerns of your constituents and any other questions you may have.

Sincerely,

Vernon M. Arrell

Vernon M. Arrell
Commissioner

cc: District Office

RICHARD A. GILMAN, M.D., F.A.C.S.
171 OLD RANCH ROAD
CHULA VISTA, CALIFORNIA 92010
—
TELEPHONE 420-0655

THORACIC SURGERY
CARDIOVASCULAR SURGERY
ENDOSCOPY

I would like to reiterate, that I speak only for myself, and in no official capacity. What I am stating are observations made over the years and complaints heard from other doctors.

The problems the medical consultants face are the usurpation by management, of their medical opinion, to suit their needs. Management decides what medical consultant exams are necessary to adjudicate a claim, irrespective of medical opinion.

Management will attach a note to the chart ordering the medical consultant to adjudicate the claim according to the dictates of management, no matter what the real issue is. The note is than removed prior to the charts completion, so that in the final analysis, it appears that the medical consultant acted independently.

Ultimately the only one who can sign out a chart is the medical consultant, so from a legal standpoint he is going to be blamed. Management makes absolutely certain that no where is their proof of any interference from management.

Management does this to keep their paper statistics at an acceptable level no matter what the real evaluation or truth happens to be.

They are able to accomplish this by threating to bring charges of insubordination or failure to cooperate.

Unfortunately, the medical consultants to date had little recoursee, as their steward, instead of acting, has been a great procrastinator and the medical consultant II only wants to ingratiate himself with management.

RAG

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

February 3, 1987

The Honorable Dorcas R. Hardy
Commissioner of Social Security
Social Security Administration
Room 900 Altmeyer
6400 Security Boulevard
Baltimore, Maryland 21235

Dear Commissioner Hardy:

We are seriously concerned about the adverse consequences for program administration and public service that could result from budgetary and staffing reductions that have been proposed for the State disability determination services and for the Social Security Administration (SSA). Specifically, we have heard many alarming reports from the State agencies that process disability claims on behalf of SSA that they are substantially underfunded, and that continued reductions in funding will undermine the proper implementation of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460). We are also concerned that the drastic reduction in SSA staffing levels recommended by the President's FY 1988 budget is unwarranted, and would significantly lower the quality of administrative service the agency provides to the American public.

With respect to the administration of the disability program, we have heard from several State agencies that the budgetary constraints that have been imposed upon them are working to jeopardize the intent of the 1984 reform legislation. Many State agencies appear to lack adequate staffing and resources, and have told us that SSA has not been consistent or forthright in providing guidelines on what to expect and plan for in the future. Additionally, some States argue that SSA's productivity measures are not accurate, realistic, or nationally uniform, and that continued underfunding and understaffing will make it impossible for State agencies to correctly apply the new standards to both initial and continuing review cases. These problems contribute to a continued atmosphere of crisis, and confound the fundamental goal of the 1984 amendments -- the restoration of order and stability to the program.

As you know, it was the clear purpose of the disability reform legislation of 1984 to clarify the standards for determining disability and to improve the quality and thoroughness of decision-making. Placing excessive and unnecessary pressures on State agencies to reduce expenditures could frustrate both these objectives. The promulgation of regulations and administrative guidelines for implementing the new medical improvement standard was long delayed, and it may not be fair or appropriate to expect States to incorporate these new changes (and the increasing work load they entail) in the disability determination process while simultaneously reducing State agency resources. If State agencies are forced to cut corners and speed decision-making without thorough case development, the problems of poor documentation and inconsistent determinations will continue to plague this program. The long-term objectives of the 1984 amendments should not be sacrificed to satisfy minor, short-term savings in the administrative budget.

On the question of SSA staffing levels, we have serious doubts that SSA can substantially reduce employment and at the same time maintain competent service to the public. We have not seen compelling evidence that SSA's systems modernization efforts -- which are reportedly way behind schedule -- in any way justify the size and scale of staffing reductions that have been proposed. SSA's work load is increasing and likely will continue to grow as a result of general demographic forces as well as specific legislative initiatives (e.g., the requirement in the Tax Reform Act of 1986 that taxpayers identify the social security number of all dependents over the age of five). The probable product of inappropriate or premature staffing cuts will be longer waiting times in SSA district offices, lower quality phone service, and an even greater demoralization of the SSA work force.

We have been given reports indicating that overtime has been frozen and positions are being left vacant in field offices pending implementaton of your announced policy of transferring central office personnel to field office positions. We are extremely concerned about both the short-term and long-term effects on field office performance of this policy, and we would like to receive from you as soon as possible the budget and management rationale for these actions.

In the next few weeks, the Subcommittee on Social Security of the Committee on Ways and Means will begin a series of hearings on SSA's management and service delivery and the budget issues we have raised. Through this process we intend to carefully scrutinize the condition of the State disability determination services and SSA staffing issues. We will expect you to describe what steps you are taking to assure that both State agencies and SSA are adequately staffed and funded to accomplish the fundamental objectives of the social security program. We would appreciate your furnishing the Subcommittee on Social Security as much information as possible concerning the reasoning behind the budget and management policies which we have questioned in this letter prior to the beginning of Subcommittee hearings at the end of February.

Sincerely,

Dan Rostenkowski

Dan Rostenkowski, Chairman
Committee on Ways and Means

J. J. Pickle

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Subcommittee on Oversight

Andy Jacobs, Jr., Chairman
Subcommittee on Social Security

ITEM 17

HOMECARE

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STATEMENT BY THE NATIONAL ASSOCIATION FOR HOME CARE BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

The National Association for Home Care is the nation's largest professional organization representing the interests of home health agencies, homemaker-home health aide organizations and hospices, with approximately 5,000 member organizations. Many of the patients our members serve are older Americans who are frail and need special assistance to remain in their homes, so we are pleased to have this opportunity to comment on the Administration's proposed Fiscal 1988 budget and its effect on the nation's elderly.

We are very concerned with the financial burdens the proposed budget would place on the elderly. The Administration proposes to require new Medicare beneficiaries to pay higher Part B premiums than current beneficiaries (35 percent of program costs for new beneficiaries, compared with 25 percent for current beneficiaries). In addition the budget would delay Medicare eligibility to the first day of the month following the 65th birthday. These proposals come at a time when 20 percent of the elderly already spend over 15 percent of their income on health care, in spite of Medicare, and 7 percent spend more than 25 percent of their income.

The Administration is also proposing continuing to shift Medicaid costs to the states by capping Federal Medicaid matching funds at $1.3 billion below projected needs, and reducing administrative support. Further reductions in Federal Medicaid funds would mean that many indigent elderly individuals would go without the health care services they need.

The reauthorization of the Older Americans Act is another issue of interest to us. That Act provides Federal funding to State Agencies on Aging for a broad variety of community-based services, including a variety of home care services. The Administration had proposed a number of measures which would narrow the access of older Americans to programs under this title, and would restructure the programs in ways which may reduce the quality of services as well as the quantity of services. Such proposals should be rejected. The Older Americans Act should be reauthorized, and improved by adding federal minimum standards for training and supervision for caregivers in home care.

REPRESENTING THE NATION'S HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES.

Of equal concern with what the Administration proposals include is what they do not include. The Administration budget and other proposals contain no relief from current Administration efforts to constrict the Medicare home health benefit or to make home health care more accessible to elderly Americans who need assistance to avoid institutionalization in a hospital or nursing home.

As the Senate Special Committee on Aging noted in its 1986 report on home health, since Congress changed the method for payment of hospital services for Medicare patients in 1983 to a prospective system, Medicare patients have been sent home from the hospital after shorter stays and in greater need of follow-up services. At the same time, the Health Care Financing Administration (HCFA), which administers the Medicare and Medicaid programs, has reduced payment levels for home health services and has narrowed its interpretation of the scope of the benefit. The result is that more Medicare beneficiaries need home health care at a time when less care is available.

To receive home health services under Medicare, a beneficiary must be under the care of a physician, be confined to his or her home (homebound), in need of skilled nursing care on an intermittent basis, or in need of physical or speech therapy. Once those requirements are met, a beneficiary may receive part time or intermittent nursing care, physical, occupational or speech therapy, medical social services, part time or intermittent services from a home health aide, and medical supplies and equipment (other than drugs and biologicals).

The major problem with the Medicare home health benefit is that increasing numbers of seriously ill Medicare patients are in need of home health care, but ever larger numbers are being denied access to care as a result of government policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers.

To resolve these problems, Congress should:

- Insure reasonable, fair and appropriate application of the Medicare requirement that home health care be provided on an "intermittent" basis, by clarifying that "intermittent" care means daily care (seven days a week) of one or more visits a day for up to 90 days, and thereafter under exceptional circumstances;

- Codify the current guideline regarding the Medicare requirement that beneficiaries must be "homebound" to clarify that homebound does not mean bedbound, but allows infrequent or short duration absences from the home primarily for medical treatment or occasional non-medical purposes;

- Oppose HCFA circumvention of the regulatory process and require HCFA to comply with the Federal Administrative Procedures Act in providing notice to agencies of proposed changes in critical Medicare policies regarding home health;

- Clarify application of the prompt payment provision of the Sixth Omnibus Reconciliation Act of 1986 (SOBRA, P.L. 99-509) to set timeliness standards for claims subject to medical review and claims other than "clean claims", so that the majority of home health claims are subject to a determination by the fiscal intermediary by a specified time; and

- Provide additional Medicare reimbursement for high technology services which require significantly more time or training to perform, to take care of those patients being discharged from hospitals sicker and quicker.

In addition, Congress should enact a catastrophic health insurance plan that includes a home care focus, as well as improved coverage for both acute and chronic long term illnesses and debilitating impairments such as Alzheimer's disease. Major catastrophic proposals under discussion cover only acute care, and would provide financial relief for only a small percent of elderly Americans. In addition, they would maintain the institutional bias of current Federal health care programs, when research and public opinion polls consistently demonstrate that most older Americans would prefer to remain in their homes and receive care there if it is at all possible.

These are the issues which confront Congress this session, as well as those outlined in the Administration's budget proposals. We urge Congress to act on these issues to maintain the home health benefit as an increasingly important element in the Medicare program, and to provide meaningful catastrophic health coverage to an elderly population whose health and financial security are both at risk.